024063 FEB 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 052937 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Betty / BETTY; MIDDLE: ; LAST: Hanan / HANAN				2a. DATE OF DEATH MONTH: 2 DAY: 20 YEAR: 89	2b. HOUR: 1045 A.M.
3. SEX: Female	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: 5 DAY: 21 YEAR: 1904		6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD County	MD.
10. CITY OR TOWN OF DEATH: COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD County GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Howard	13c. CITY OR TOWN: Columbia	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: #401 6150 Foreland Grath / 21045	
14. FATHER'S NAME FIRST / MIDDLE / LAST: Unavailable				15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Unavailable	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 051-05-4344		17. INFORMANT: Marlene Marsh,	ADDRESS: 14 Cynthia Drive Farmingville, NY 11738

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

(b): systemic sepsis (probable)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): severe hypokalemia · intermittent left ventricular failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/1/89, 19 89, to 2/20, 19 89, that (I) (we) last saw the deceased alive on 2/20, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: David A. Blass	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ CONSULTING PHYSICIAN STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/20/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAVID A. BLASS	22e. ADDRESS: 2 KNOLL NORTH DRIVE COLUMBIA MARYLAND 21045		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-23-89	23c. NAME OF CEMETERY OR CREMATORY: Beth David Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Elmont, New York	
24. FUNERAL DIRECTOR NAME: Weinstein West End Funeral Chapel ADDRESS: 1283 Coney Island Ave., Brooklyn, NY 11230	25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Githa Davidson-Randall		

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

021936 FEB 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

Cleared by Medical Examiner

89 05294

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Clara	D.	Heldreth	Feb. 2, 1989	6:00 P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Oct. 11 1902	86 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	USA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Howard MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Ellicott City	3004 North Ridge Road	Adm. Clerk	A.A.A.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 21043

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Howard	Ellicott City	YES ☒ NO ☐	3004 North Ridge Road

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Walter	E.	Deyerle	Elizabeth		Price

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A	N/A	578-40-1617	Leo M. Heldreth-son-	Annapolis, Md. 943 Mastline Drive

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary atherosclerosis	yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Mid '87 to 2 Feb 89 that (I) (we) last saw the deceased alive on Sep-Oct 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Gustavo S Belaval	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	3 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Gustavo S. Belaval, MD	3701 Roosmoor Blvd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 6, 1989	Cedar Hill Cemetery	Suitland Pr. Georges Md.

24. FUNERAL DIRECTOR (NAME)	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home, 11800 N.H. Ave., Silver Spring, Md.	FEB 6 1989	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Items 18athru22a per M.E. Film G650 4/7/89 cc

024499 MAR - 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 052995

1. DECEASED NAME (TYPE OR PRINT) FIRST: Paula	MIDDLE: M.	LAST: Henry	2a. DATE KNOWN OF DEATH ESTIMATED ☐ XX MONTH DAY YEAR: 2-19 19 89	2b. HOUR: M			
3. SEX: female	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: JULY 12,1959	6. AGE (IN YEARS LAST BIRTHDAY): 29 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-19 19 89	2d. HOUR: 2:48 p. M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): JAMAICA	7b. CITIZEN OF WHAT COUNTRY?: JAMAICA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County, MD.				
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DIETICIAN	12b. KIND OF BUSINESS OR INDUSTRY: HOSPITAL				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: HOWARD	13c. CITY OR TOWN: COLUMBIA	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS: 5491 WOODEN HAWK CIRCLE 21044			
14. FATHER'S NAME FIRST: PAUL	MIDDLE	LAST: JOHNSON	15. MOTHER'S MAIDEN NAME FIRST: BARBARA	MIDDLE	LAST: THOMPSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-13-5465	17. INFORMANT: HOMER HENRY	ADDRESS: 5491 WOODEN HAWK CIRCLE COLUMBIA, MD. 21044			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Amniotic fluid embolism	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF	(b) Spontaneous uterine rupture	
DUE TO, OR AS A CONSEQUENCE OF	(c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES X NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-20-89

EXAMINER'S NAME (TYPE OR PRINT): James A. Kaplan, M.D. ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
BURIAL	2/24/89	MEADOWRIDGE	DORSEY	MARYLAND

24. FUNERAL DIRECTOR (NAME) LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A.
5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045

25a. DATE REC'D. BY REGISTRAR: FEB 27 1989

25b. REGISTRAR'S SIGNATURE: Lia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL OR REMOVAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP DHMH - 12 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005296

024384 MAR 2 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Robert — MIDDLE: Bolling — LAST: Kelly

2a. DATE OF DEATH — MONTH DAY YEAR: 01 23 89

2b. HOUR: 907 PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: 06-09-13

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard MD.

10. CITY OR TOWN OF DEATH: Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED

12b. KIND OF BUSINESS OR INDUSTRY: U.S. NAVY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: HOWARD

13c. CITY OR TOWN: COLUMBIA

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 5509 OLD COLUMBIA RD 21045

14. FATHER'S NAME — FIRST: FRANCIS — MIDDLE: C — LAST: KELLY

15. MOTHER'S MAIDEN NAME — FIRST: JULIA — MIDDLE: — LAST: LATHROP

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 031-30-2060

17. INFORMANT — ADDRESS: BARBARA KELLY 5509 OLD COLUMBIA RD COLUMBIA MD 21045

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Staphylococcal pneumonia & meningitis — 7 days

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): - long term corticosteroid use - temporal arteritis

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from January 16, 19 89, to January 23, 19 89, that (I) (we) last saw the deceased alive on January 23, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: David A. Blass MD — DEGREE: MD — CONSULTING ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAVID A. BLASS

22e. ADDRESS: 2 KNOLL NORTH DRIVE COLUMBIA MD 21045

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 1-30-89

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON

23d. LOCATION — CITY OR TOWN: ARLINGTON — COUNTY — STATE: VA

24. FUNERAL DIRECTOR — NAME & ADDRESS: HARRY H. WITZKE INC. ELLICOTT CITY MD 4112 COLUMBIA PK 21043

25a. DATE REC'D. BY REGISTRAR: JAN 26 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 20

DHMH - 16 60M 7/84
(VRA 15, 4)

025232 MAR 14 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005297

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
ALLEN	Thomas	HILL	2	27	89	7 20 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
M	C	3	11	28	60 YRS.	11	16		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Howard Co., MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
WOODBINE	16070 A.E. Mullinix Road	AUCTIONEER	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE
MD	Howard	WOODBINE		16070 A.E. MULLINIX RD 21797

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	Harvey	Hill	Elva	Dorsey	Iglehart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	217-30-3596	Elizabeth H. Hill, Same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ESOPHAGEAL CANCER, METASTATIC — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from July 19 82 to 2/27 19 89 that (I) (we) last saw the deceased alive on 2/26 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Evelyn Jamison	5540 Tin Top Rd Clarksville, MD 21029

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2-2-1989	Mt. View		Howard	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Charles W. Burrier, Jr.	Sykesville, Md.	FEB 28 '89	Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove duplicate pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 60M 7/84 (VRA 15, 4)

024508 MAR -2 89

1a FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 052988

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ELEANOR	MARY	HOLDEN	FEBRUARY 24, 1989	3:25 am

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	OCTOBER 21, 1905	83 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		HOWARD COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
ELLICOTT CITY	BON SECOUR EXTENDED CARE	BUYER	HUTZLER'S DEPT.ST.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	HOWARD	ELLICOTT CITY	YES ☐ NO XX	3958 OLD COLUMBIA PIKE 21043

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JAMES		DUGAN	ELLA	T.	HOGAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		218-12-8574	ELIZABETH CLEMENTS	3958 OLD COLUMBIA PIKE ELLICOTT CITY, MD. 21043

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) R HEMISPHERIC STROKE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11/88 - 2/24/89

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) MULTI-INFARCT DEMENTIA.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Glen E Johnson MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GLEN E JOHNSON MD.	1001 PINE HEIGHTS AVE. BALTO. MD. 21229

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	02/27/89	GOOD SHEPHERD	ELLICOTT CITY MARYLAND

24. FUNERAL DIRECTOR (NAME) ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	FEB 27 1989	Jacqueline Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remail remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024407 MAR -2 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 052999
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harry	MIDDLE: Martin	LAST: Homens	2a. DATE OF DEATH MONTH: February	DAY: 23	YEAR: 89
2b. HOUR: 4:20 A M					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 5, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.		
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Manager (Ret)	12b. KIND OF BUSINESS OR INDUSTRY: Warehouse		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Queen Anne	Queenstown	YES [ ] NO [X]	12 Greenwood Creek Rd. 21658

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
William / Homens	Sophia / (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife) ADDRESS	
No	-	215.09.1114	Marie T. Homens	Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorpulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive Cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic obstructive lung disease. Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 80, to February 23, 19 89, that (I) (we) last saw the deceased alive on February 23, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Charles E. Taylor MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	2-23-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Charles E. Taylor MD	2 Knoll North Drive, Columbia MD 21045

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 27, 1989	St. Peter's Church Cem.	Queenstown, Queen Anne Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Singleton Funeral Home, Glen Burnie, Maryland	FEB 28 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of each.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023353 FEB 2 1989

Items 18a, 22a per M.E. Film G650 4/7/89 CG

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 053 00 REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)	FIRST: George	MIDDLE: M.	LAST: Howsare	2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ]	MONTH: 2 DAY: 9 YEAR: 19 89
2b. HOUR OF DEATH	3. SEX: Male	4. RACE: White	5. DATE OF BIRTH (MONTH DAY YEAR): OCt. 3, 1944	6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
2c. DATE PRONOUNCED DEAD	MONTH: 2 DAY: 9 YEAR: 19 89	2d. HOUR OF PRONOUNCED DEAD: 10:10 A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.		
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Parking lot of 7th Day Adventist Center Martin Road	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Surveyor	12b. KIND OF BUSINESS OR INDUSTRY: State of MD		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hancock	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: Route 2, Weller Rd./ 21750	
14. FATHER'S NAME FIRST: William	MIDDLE: Bruce	LAST: HOwsare	15. MOTHER'S MAIDEN NAME FIRST: Eleanor	MIDDLE:	LAST: Hite
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Viet Nam	16b. SOCIAL SECURITY NO.: 213-40-4163	17. INFORMANT: Janna Dignan (Daughter)	ADDRESS: 108 Karns Avenue Cumberland, MD	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Mario F. Golle Jr. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-10-89

VC EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr., M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-13-89	23c. NAME OF CEMETERY OR CREMATORY: MSVC-Rocky Gap	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Flintstone-Allegany-Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: George-Upchurch FUneral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502	25a. DATE REC'D. BY REGISTRAR: FEB 13 1989	25b. REGISTRAR'S SIGNATURE: [signature]	

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

23079 FEB 7 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 05301

1. DECEASED NAME (TYPE OR PRINT): FIRST Ethel MIDDLE Frances LAST Johnson

2a. DATE OF DEATH: MONTH 2 DAY 14 YEAR 89

2b. HOUR 5:45 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 3 DAY 6 YEAR 08

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.

10. CITY OR TOWN OF DEATH: Ellicott City

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bon Secours Extended Care Facil.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk

12b. KIND OF BUSINESS OR INDUSTRY: Westinghouse

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Baltimore

13c. CITY OR TOWN: Catonsville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 801 Winters Lane, Apt. 325 21228

14. FATHER'S NAME: FIRST Samuel MIDDLE Leonard LAST Bateman

15. MOTHER'S MAIDEN NAME: FIRST Alice MIDDLE LAST Fromm

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 212-10-4899

17. INFORMANT: Mildred Sasso ADDRESS: 900 Prestwood Rd. 21228

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio - pulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 mins.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): multiple CVA — 2 years.

DUE TO, OR AS A CONSEQUENCE OF (c): stroke syndrome — 2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive heart failure, Pneumonia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/11, 19 87, to 2/14, 19 89, that (I) (we) last saw the deceased alive on 2/11, 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles Sheehan, M.D.

22e. ADDRESS: 10298 Balto. Natl. Pike 21043

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-17-89

23c. NAME OF CEMETERY OR CREMATORY: Western Cemetery

23d. LOCATION: CITY OR TOWN Baltimore COUNTY STATE MD

24. FUNERAL DIRECTOR NAME: Hubbard Funeral Home, Inc. ADDRESS: 4107 Wilkens Ave. 21229

25a. DATE REC'D. BY REGISTRAR: FEB 15 1989

25b. REGISTRAR'S SIGNATURE: June Davidson-Kendall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified promptly.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

022147 FEB 9 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

OR 1 - STATE REGISTRAR RICHARD P. KAPUTA

89 05302 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
RICHARD	P.	KAPUTA	2/6/89	12:25 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	DECEMBER 30, 1923	65 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
CONNECTICUT	U.S.A.		HOWARD COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
COLUMBIA	HOWARD COUNTY GENERAL HOSPITAL	EXECUTIVE -BOYS	CLUB OF AMERICA

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	HOWARD	COLUMBIA	YES ☐ NO XX	5495 CEDAR LANE APT. 305 21044

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN		KAPUTA	MARY		HOMA

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	044-16-1621	JOSEPHINE KAPUTA	922 MASEFIELD ROAD BALTIMORE, MARYLAND 21207

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PROBABLE SEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 36 HOURS
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): END STAGE RENAL DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Sudhi Chintrisna	MD	ATTENDING PHYSICIAN X	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SUDHI CHINTRISNA, MD.	11085 LITTLE PATUXENT PKWY, COLUMBIA MD. 21044

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/9/89	MARYLAND VETERANS-GARRISON FOREST	OWINGS MILLS MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	FEB 7 1989	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024498 MAR-2 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR JOSEPH S. KEEHNER — REG. NO. 89 05303

1. DECEASED NAME (TYPE OR PRINT): FIRST JOSEPH; MIDDLE STEWART; LAST KEEHNER

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐: MONTH 2 DAY 25 YEAR 1989 — 2b. HOUR 6:30 P.M.

3. SEX: MALE — 4. RACE: WHITE — 5. DATE OF BIRTH: MONTH 6 DAY 13 YEAR 29 — 6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 25 YEAR 1989 — 2d. HOUR 7:30 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD.

10. CITY OR TOWN OF DEATH: COLUMBIA — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY GEN. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SYSTEMS ADMINISTRATOR — 12b. KIND OF BUSINESS OR INDUSTRY: SOCIAL SECURITY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: HOWARD — 13c. CITY OR TOWN: COLUMBIA — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 6465 BELLVIEW DRIVE 21046

14. FATHER'S NAME: FIRST JOSEPH; MIDDLE; LAST KEEHNER

15. MOTHER'S MAIDEN NAME: FIRST MYRTLE; MIDDLE; LAST STEWART

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-26-7867

17. INFORMANT: MARILYN KEEHNER — ADDRESS: 6465 BELLVIEW DRIVE COLUMBIA, MD. 21046

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immediate
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of the lung — 3 months
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Scott Maurer — M.D. — TITLE (SPECIFY): MD — MEDICAL EXAMINER — DATE SIGNED: 2/25/89

EXAMINER'S NAME (TYPE OR PRINT): SCOTT MAURER MD — ADDRESS: 2850 NORTH RIDGE RD E.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 3/1/89 — 23c. NAME OF CEMETERY OR CREMATORY: CRESTLAWN — 23d. LOCATION CITY OR TOWN: MARRIOTTSVILLE COUNTY / STATE: MARYLAND

24. FUNERAL DIRECTOR NAME AND ADDRESS: LEROY M. & RUSSELL C. WITZKE FUNERAL HOME 5555 TWIN KNOLLS RD. COLUMBIA, MD. 21045 — 25a. DATE REC'D. BY REGISTRAR: FEB 27 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 17
(VR A15 ME (5))
15M2/80

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" (PENDING AUTOPSY, ETC.) IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL

024124 FEB 29-89

Item#18a,22a per M.E. FilmG650 4/3/89CG

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 5 3 0 4

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST
Jessica	S.	Kim

2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ — MONTH 2 DAY 17 YEAR 1989 — 2b. HOUR M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	11 06 88		3			

2c. DATE PRONOUNCED DEAD — MONTH 2 DAY 17 YEAR 1989 — 2d. HOUR 4:25 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		Howard County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Columbia	Howard County General Hospital	N/A	N/A

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	BALTIMORE	CATONSVILLE	YES ☐ NO ☒	7418 LASADA DRIVE APT 1B 21207

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
TONG	SOO	KIM	MYUNG		CHO

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		N/A	SUK JIN CHO 9677 GWYNN PARK DR. ELLICOTT CITY, MD 21043

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2/17/89

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	02/20/89	CRESTLAWN CEMETERY	MARRIOTTSVILLE MARYLAND

24. FUNERAL DIRECTOR (SIGNATURE)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE, MD 21228	FEB 22 1989	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP391 DHMH - 17 (VR A15 ME (5))

022614 FEB 1 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05305 REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: KUM	MIDDLE: HWA	LAST: KIM	2a. DATE OF DEATH MONTH: 2 DAY: 3 YEAR: 89	2b. HOUR: 946 AM	
3. SEX: FEMALE	4. RACE: Oriental	5. DATE OF BIRTH MONTH: 1 DAY: 3 YEAR: 18	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Korea	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD County MD.		
10. CITY OR TOWN OF DEATH: COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	HOWARD	COLUMBIA	YES ☐ NO ☒	5145 COLUMBIA ROAD 21044

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
UNKNOWN	UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	-----	214-98-5713	Mr. Richard Kim 1204 Dulaney Woods RD. Cockeysville, MD 21030

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Pancreatic Cancer

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Carl Bianco M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Carl Bianco	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/4/89	Dulaney Valley Mem.	Cockeysville Baltimore MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Loring Byers Funeral Directors, Inc	8728 Liberty Road Randallstown, MD 21133	FEB 10 1989	Gloria Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024844 MAR -7 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 05306
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use with the Report of Disposition and Transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Otto	MIDDLE: J	LAST: Koch. JR	2a. DATE OF DEATH MONTH DAY YEAR: 02 28 89	2b. HOUR: 1515 M	
3. SEX: Male	4. RACE: Cauc	5. DATE OF BIRTH MONTH DAY YEAR: 01 24 09	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County	MD.	
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Chemical Oper.	12b. KIND OF BUSINESS OR INDUSTRY: Dupont		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	A.A.	Baltimore	YES ☐ NO ☒	#8 Thomas Avenue 21225

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Otto J. Koch Sr	Rebecca Baldwin	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS	
NO	216-10-7296	Mary C. Koch	Same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5m

DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary hemmorhage — 12 hrs

DUE TO, OR AS A CONSEQUENCE OF (c): Lung Cancer

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 12 19 88, to 2/27 19 89, that (I) (we) last saw the deceased alive on 12/28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Warren M Ross MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/28/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Warren M. Ross M.D.	11065 Little Patuxent Parkway Columbia Md 21044

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3/4/89	Holy Cross Cemetery	Baltimore A. A. Md

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George J. Gonce 4001 Ritchie Highway Balto Md 21225	MAR 3 - 1989	Julia Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15. 4)

023726 FEB 2 6 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05307
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: John	MIDDLE	LAST: LINARDI	2a. DATE OF DEATH MONTH DAY YEAR: 2/20/89	2b. HOUR: 12 55 A M	
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: 08 21 99	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Italy	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD MD.		
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Shoe Repairman	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: md	13b. COUNTY	13c. CITY OR TOWN: Balt	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 4310 Biddison La. 21206	
14. FATHER'S NAME FIRST: John	MIDDLE	LAST: Linardi	15. MOTHER'S MAIDEN NAME FIRST: Angela	MIDDLE	LAST: Possidenti
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-34-3764	17. INFORMANT ADDRESS: Angela Beltram, 3125 Paulskirk Dr., Ellicott City 21043		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asystole.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (c): Congestive Heart Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertrophic Cardiomyopathy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 02 FEB, 19 89, to 20 FEB, 19 89, that (I) (we) last saw the deceased alive on 19 FEB, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bruce Conger — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BRUCE M. CONGER MD

22e. ADDRESS: SUITE 104 MOST LITTLE PARKWAY, COLUMBIA MD 21044

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-23-89	23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Balto., Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS: Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214		25a. DATE REC'D. BY REGISTRAR: FEB 22 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 053038 REG. NO.

024484 MAR 2 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Marie (MARY) — MIDDLE: — LAST: Lubic
2a. DATE OF DEATH — MONTH DAY YEAR: February 15, 1989
2b. HOUR: 5 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: August 3, 1902
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.
10. CITY OR TOWN OF DEATH: Ellicott City MD
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bon Secour Extended Care Fac
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Copy writer
12b. KIND OF BUSINESS OR INDUSTRY: DEp't store
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Howard
13c. CITY OR TOWN: Marriottsville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 12080 Old Frederick Rd 21104
14. FATHER'S NAME — FIRST MIDDLE LAST: Joseph Lubic
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Barbara Subasic
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. SOCIAL SECURITY NO.: 172 07 0726
17. INFORMANT: Joann Hughes Old Frederick Rd Marriottsville 21104

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): CHRONIC ASPIRATION
DUE TO, OR AS A CONSEQUENCE OF (c): MULTIPLE ESOPHAGEAL STRICTURES
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/27/89, 19 to 2/15/89, 19, that (I) (we) last saw the deceased alive on 1/27/89, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/15/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): OKEAN MD
22e. ADDRESS: 3460 ELLICOTT CENTER DR Ellicott City MD 21043

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 18, 1989
23c. NAME OF CEMETERY OR CREMATORY: St Marys
23d. LOCATION — CITY OR TOWN: McKees Rocks COUNTY: Penna STATE:
24. FUNERAL DIRECTOR — NAME ADDRESS: Harry H Witzke 4112 Columbia Pike Ellicott City
25a. DATE REC'D. BY REGISTRAR: FEB 16 '89
25b. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use in the event a transit permit is required. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 60M 7/84
(VRA 15, 4)

023904 FEB 28 89

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05309
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: NORMAN	MIDDLE: FRANKLIN	LAST: MaCARTHY	2a. DATE OF DEATH MONTH: 1 DAY: 29 YEAR: 89	2b. HOUR: M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 12 DAY: 6 YEAR: 05	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASS.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard MD.		
10. CITY OR TOWN OF DEATH: ELLICOTT CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ~~9606 Frederick Rd.~~ 9606 Frederick Rd	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	Howard	ELLICOTT CITY	YES ☐ NO ☐	9606 Frederick Rd. 21043

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ROBERT	JOHN	MaCARTHY	ALBINA		CIARLO

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES		021-03-2086	Frances MaCarthy	9606 Frederick Rd. Ellicott City, Md. 21043

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease
DUE TO, OR AS A CONSEQUENCE OF (c) CA of the bladder + mets
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐					

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/21 19 80 to 1/29 19 89 that (I) (~~not~~) last saw the deceased alive on 1/17 19 89 and that in (my) (~~not~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~have not~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
	MD	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☑	STAFF PHYSICIAN ☐	2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Luis M. Zuniga, M.D.	1101 Maiden Choice La., Balto., MD 21229

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Removal	1-29-89				

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
State Anatomy Board	Balto., Md.	FEB 24 1989	Gina Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

23090 FEB 17 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG NO. B 9 0 5 3 1 0

1. DECEASED NAME (TYPE OR PRINT): FIRST JOHN MIDDLE CHARLES LAST MALKMUS

2a. DATE OF DEATH: MONTH 2 DAY 15 YEAR 89

2b. HOUR 12:03 A M

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: MONTH 7 DAY 8 YEAR 1915

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N Y

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARITAL STATUS: MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD CO. MD.

10. CITY OR TOWN OF DEATH: ELKRIDGE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6554 BELMONT WOODS RD

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALESMAN

12b. KIND OF BUSINESS OR INDUSTRY: PUMPS

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: HOWARD

13c. CITY OR TOWN: ELKRIDGE

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 6554 BELMONT WOODS RD

14. FATHER'S NAME: FIRST JOHN MIDDLE LAST MALKMUS

15. MOTHER'S MAIDEN NAME: FIRST ELFRIEDA MIDDLE CORNELIA LAST KELLNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): 1942 - 1945

16b. SOCIAL SECURITY NO.: 081-01-3152

17. INFORMANT: JEAN M. MALKMUS ADDRESS: 6554 BELMONT WOODS RD ELKRIDGE MD. 21227

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Prostate Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 18, 19 88, to Feb 15, 19 89, that (I) (we) last saw the deceased alive on Jan 30, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles Padgett MD — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CHARLES PADGETT MD

22e. ADDRESS: 5601 Loch Raven Blvd Baltimore, MD 21239

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: 2/15/89

23c. NAME OF CEMETERY OR CREMATORY: WESTVIEW MEM PARK

23d. LOCATION: CITY OR TOWN BALTIMORE COUNTY CO. STATE MD

24. FUNERAL DIRECTOR NAME: JOSEPH L. CANBY ADDRESS: 12590 INDIAN HILL DR SYKESVILLE MD 21784

25a. DATE REC'D. BY REGISTRAR: FEB 15 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1660M 1/75
(VR A 15 (4))

023649 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 053111

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Estelle	MIDDLE: A.	LAST: Matthews	2a. DATE OF DEATH MONTH: February	DAY: 13	YEAR: 1989
2b. HOUR: 6:30 PM					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: November DAY: 13 YEAR: 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:
IF UNDER 24 HRS. HOURS:	MIN.:				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard MD.		
10. CITY OR TOWN OF DEATH: Woodbine	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Tara Retirement Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bookkeeper	12b. KIND OF BUSINESS OR INDUSTRY: Hardware		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Virginia	13b. COUNTY: Fairfax	13c. CITY OR TOWN: McLean	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 6726 Benjamin Street 22101	
14. FATHER'S NAME FIRST: Frank	MIDDLE:	LAST: Yeager	15. MOTHER'S MAIDEN NAME FIRST: Callie	MIDDLE:	LAST: (Unavailable)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 233-32-9926	17. INFORMANT: Rosamond Matthews, Daughter in Law,	ADDRESS: Same as item #13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Dehydration
DUE TO, OR AS A CONSEQUENCE OF (c): Organic brain Syndrome
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): advanced age

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-6 19 87, to February 13 19 89, that (I) (we) last saw the deceased alive on 2-9 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John L Ford DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John L. Ford, MD

22e. ADDRESS: 12520 Prosperity Drive #150 Silver Spring, MD 20904

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/14/89	23c. NAME OF CEMETERY OR CREMATORY: Suburban Crematory	23d. LOCATION CITY OR TOWN: Silver Spring COUNTY: Maryland STATE:
24. FUNERAL DIRECTOR NAME: Rapp Funeral Services, P.A. ADDRESS: 933 Gist Avenue, Silver Spring, Maryland 20910	25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH - 16 60M 7/84
(VRA 15, 4)

023778 FEB 2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 89 053 12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Virginia	Brewington	Messick	2a. DATE OF DEATH MONTH DAY YEAR	Feb. 6, 1989
				2b. HOUR	11:45 A M
3. SEX	Female				
4. RACE	Caucasian				
5. DATE OF BIRTH MONTH DAY YEAR	11 1 1915			6. AGE (IN YEARS LAST BIRTHDAY)	73 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS				IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland			7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐				9. BALTIMORE CITY OR COUNTY OF DEATH	Howard County MD.
10. CITY OR TOWN OF DEATH	Ellicott City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Bon Secours Extended Care
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Homemaker			12b. KIND OF BUSINESS OR INDUSTRY	Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					21207
13a. STATE	Maryland	13b. COUNTY	Baltimore	13c. CITY OR TOWN	BALTIMORE
13d. INSIDE CITY LIMITS? YES ☐ NO ☒		13e. STREET ADDRESS	1524 Forrest Pk. Ave.		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Morris	Brewington		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Effie Shriver
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	N/A	16b. SOCIAL SECURITY NO.	214-10-7654
17. INFORMANT	Lynn Messick	ADDRESS	10 Broadview Terr. Orinda, Cal. 94563		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Bronchogenic Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 month
DUE TO, OR AS A CONSEQUENCE OF (b) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/14 1988 to 2/6 1989, that (I) (we) last saw the deceased alive on 1/31 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	MD		2/6/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Bernard Farrell, M. D.	22e. ADDRESS	11055 Little Patuxent Pkwy Columbia, MD 21044

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Cremation	02-07-89	Security Process	Catonsville, BA., MD	
24. FUNERAL DIRECTOR NAME / ADDRESS	[redacted] Bounds Funeral Home, 705 E. Main Street, Salisbury, MD	25a. DATE REC'D. BY REGISTRAR	FEB 10 '89	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

024350 MAR - 2 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053 13
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE:	LAST: Moore	2a. DATE OF DEATH MONTH DAY YEAR: 2/22/1989	2b. HOUR: 4:35 A.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 6/20/1900	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County, MD.		
10. CITY OR TOWN OF DEATH: Ellicott City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5619 Montgomery Rd., 21043		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Baltimore	Dundalk	YES ☐ NO ☒	6814 Boston Ave., 21222

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Martin	Henry	Feeheley	Barbara		Herganhan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		573-07-8328	Mrs. Pat Voland	5619 Montgomery Rd., Ellicott City, Md. 21043

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac failure.
DUE TO, OR AS A CONSEQUENCE OF (b) Severe H&A.S.C.V.D.
DUE TO, OR AS A CONSEQUENCE OF (c) Severe Cerebral atherosclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from JAN. 19 19 87 to 2-22- 19 89, that (I (~~we~~) last saw the deceased alive on 10-31- 1988, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Ataollah Golpira	M.D.	☐ / ☒ / ☐	2/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Ataollah Golpira, M.D.	3029 Dundalk Ave., Dundalk, Md. 21222

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/27/89	Meadowridge Mem Pk.	Elkridge, Howard, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
McCully Funeral Homes	237 E. Patapsco Ave., Baltimore, Md. 21225	MAR 1 - 1989	Jacqueline Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024388 MAR-2185 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053 14 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Quincy		Mullins	January 13 1989	11:30pm

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male	White	September 5, 1918	70 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Tennessee	USA		Howard MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Savage	8866 Washington street	plumber	construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Howard	Savage	YES X NO ☐	8866 Washington St. 20763

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Brown	Lou	Mullins	Maud	Collins	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	1944-46	215 12 4797	Pauline Mullins above address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Core Nomatosis	
DUE TO, OR AS A CONSEQUENCE OF (c)	Bronchogenic Carcinoma	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-7 19 88 to 1-13 19 89, that (I) (we) last saw the deceased alive on 1-12-89 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
William A Warren MD	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1-14-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
W A Warren	321 Prince George St Laurel 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	January 17, 1989	Linthicum Chapel	Clarksville, Md

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donaldson Funeral Home, Laurel, Md	JAN 19 '89	Linda Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH-16 60M 1/73
(VR A 15 (4))

RECEIVED
HOWARD COUNTY
HEALTH DEPT.
ELLICOTT CITY, MD.

JAN 19 9 16 AM '89

024675 MAR 30

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 05315

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DOROTHEA	MIDDLE: NELLIE	LAST: NOONEY	2a. DATE OF DEATH MONTH: FEB	DAY: 24,	YEAR: 1989	2b. HOUR: 4 03 A M
3. SEX: F	4. RACE: C	5. DATE OF BIRTH MONTH: 12 DAY: 24 YEAR: 28	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD MD.				
10. CITY OR TOWN OF DEATH: COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY GENERAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: —				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HOWARD	13c. CITY OR TOWN: ELLICOTT	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS / ZIP CODE: 2754 Deerfield Dr 21043			
14. FATHER'S NAME FIRST: ROBERT	MIDDLE: C	LAST: ZIMMERMAN	15. MOTHER'S MAIDEN NAME FIRST: NELLIE	MIDDLE: LAURA	LAST: HANDINGHAM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): —	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 213263851	17. INFORMANT ADDRESS: Mr. Eugene J. Nooney 21043 2754 Deerfield Drive Ellicott City, MD				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Ovarian Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 YR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Malignant ascites — 3 months
DUE TO, OR AS A CONSEQUENCE OF (c): intractable nausea — 2d

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Ø

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☑
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): —	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): —	21f. LOCATION STREET: — CITY OR TOWN: — COUNTY: — STATE: —	

22a. I certify that (I) (this hospital) attended the deceased from Feb 22, 19 89 to Feb 24, 19 89, that (I) (we) last saw the deceased alive on Feb 24, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have) (did) (did not) view the body after death.

22b. SIGNATURE: Patryce A. Toye DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PATRYCE A. TOYE, MD — 22e. ADDRESS: 2850 North Ridge Rd Ellicott City MD 21043

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Entombed	23b. DATE: 2/27/89	23c. NAME OF CEMETERY OR CREMATORY: Crestlawn Cemetery	23d. LOCATION CITY OR TOWN: West Friendship COUNTY: Howard STATE: MD
24. FUNERAL DIRECTOR NAME & ADDRESS: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133	25a. DATE REC'D. BY REGISTRAR: FEB 27 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

23265 FEB 21 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053 16
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dominica	MIDDLE: Winnie	LAST: Olesnevich	2a. DATE OF DEATH MONTH DAY YEAR: february 15th, 1989	2b. HOUR: 7:07 P M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 12 1911	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Russia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.		
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Baltimore	Baltimore	YES XX NO ☐	7734 Washington Blvd. Lot # 148

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Sava		Schmirsky	Tekla		Pushniak

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
n/a	n/a	204-07-7079	Stephen Olesnevich	same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cong. heart failure, Hypotension
DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular accident
DUE TO, OR AS A CONSEQUENCE OF (c) Seizure disorder, Sick Sinus Syn.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Hx of DVT

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
PRADEEP GARG	720 Maidench Ln, Catonsville MD 21228

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/18/89	Rock Creek Cemetery	Washington, D.C.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Md. 20707	FEB 17 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

024381 MAR - 2 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 053 17
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: JOHN; MIDDLE: C.; LAST: PALARDY

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☐ — MONTH: 01; DAY: 29; YEAR: 1989

2b. HOUR: 0530 M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH — MONTH: 12; DAY: 31; YEAR: 29

6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS.

If UNDER 1 YR. — MONTHS: ; DAYS: ; If UNDER 24 HRS. — HOURS: ; MIN:

2c. DATE PRONOUNCED DEAD — MONTH: 01; DAY: 29; YEAR: 1989

2d. HOUR: 0633 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard — MD.

10. CITY OR TOWN OF DEATH: COLUMBIA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY GENERAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PLUMBING-INP

12b. KIND OF BUSINESS OR INDUSTRY: W.S.S.C.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: HOWARD

13c. CITY OR TOWN: ELLICOTT CITY

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 3229 GREENWAY DRIVE 21043

14. FATHER'S NAME — FIRST: JOHN; MIDDLE: H; LAST: PALARDY

15. MOTHER'S MAIDEN NAME — FIRST: FRANCES; MIDDLE: ; LAST: MUELLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES

(IF YES, GIVE WAR OR DATES): KOREAN

16b. SOCIAL SECURITY NO.: 217-24-4368

17. INFORMANT — ADDRESS: 3229 GREENWAY DR. 21043: ANN C. PALARDY ELLICOTT CITY MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Robert E. Ludwick — TITLE (SPECIFY): M.D. — MEDICAL EXAMINER — DATE SIGNED: 1-29-89

EXAMINER'S NAME (TYPE OR PRINT): Robert Lydicka — ADDRESS: 7055 Chevrolet Dr Ellicott City Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 1-31-89

23c. NAME OF CEMETERY OR CREMATORY: CRESTLAWN

23d. LOCATION — CITY OR TOWN: MARRIOTTSVILLE; COUNTY: HO.; STATE: MD

24. FUNERAL DIRECTOR NAME: HARRY H. WITZKE INC — ADDRESS: 4112 COLUMBIA RD 21043 ELLICOTT CITY

25a. DATE REC'D. BY REGISTRAR: JAN 31 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M

BP 15

DHMH - 17 (VR A15 ME (5))

24200 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 053 18
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): First Rayford (Raylord) Middle M. Last Perry

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ Month 2 Day 22 Year 89 — 2b. HOUR

3. SEX: male — 4. RACE: black — 5. DATE OF BIRTH: Month 10 Day 30 Year 1953 — 6. AGE (IN YEARS LAST BIRTHDAY): 35 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month 2 Day 22 Year 89 — 2d. HOUR: 6:00 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.C. — 7b. CITIZEN OF WHAT COUNTRY?: U S A — 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.

10. CITY OR TOWN OF DEATH: Ellicott City — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10132 Kings Bench Court — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: HOWARD — 13c. CITY OR TOWN: Ellicott — 13d. INSIDE CITY LIMITS? YES ☐ NO XX — 13e. STREET ADDRESS: 10132 King Bench Court 21043

14. FATHER'S NAME: First Simon Middle Last Perry

15. MOTHER'S MAIDEN NAME: First Nannie Middle Last Butler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-64-7440

17. INFORMANT: Nannie B. Greene — ADDRESS: 4706 Pimilco Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound of head
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH 2 DAY 28 YEAR 89 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): self inflicted

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home — 21f. LOCATION STREET: 10132 Kings Bench Court CITY OR TOWN: Ellicott City COUNTY: Howard County STATE: MD

22a. I certify that I took charge of the remains described above, held on Autopsy XX Inspection ☐ Inquiry ☐ and that in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide XX Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Mario F. Golle Jr. M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 2-22-89

VC EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr., M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2/27/89 — 23c. NAME OF CEMETERY OR CREMATORY: Garrison Forest Vet — 23d. LOCATION CITY OR TOWN: Owings Mills COUNTY STATE: Md

24. FUNERAL DIRECTOR NAME AND ADDRESS: Wm. C. March F/H West 4300 Wabash Avenue

25a. DATE REC'D. BY REGISTRAR: FEB 24 1989 — 25b. REGISTRAR'S SIGNATURE: Lia Davidson-Randall

TO MEDICAL EXAMINER: THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024493 MAR T2 Item 5 & 6 corrected per F.H. Film G-649 reb 3/31/89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 5 3 1 9

1. DECEASED NAME (TYPE OR PRINT): FIRST Victoria MIDDLE Life LAST Perry

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 2 DAY 22 YEAR 89 — 2b. HOUR

3. SEX: Female — 4. RACE: Negro — 5. DATE OF BIRTH: MONTH 1 DAY 31 YEAR 1947 — 6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 22 YEAR 89 — 2d. HOUR 6:00 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Philda Pa — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.

10. CITY OR TOWN OF DEATH: Ellicott City — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10132 Kings Bench Court — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant — 12b. KIND OF BUSINESS OR INDUSTRY: HIFCA

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Howard — 13c. CITY OR TOWN: Ellicott City — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 10132 Kings Bench Ct 21868

14. FATHER'S NAME: FIRST Harold MIDDLE O. LAST Waters

15. MOTHER'S MAIDEN NAME: FIRST Ruby MIDDLE Dashiell LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): Reserves — 16b. SOCIAL SECURITY NO.: 207 36 0681

17. INFORMANT: Mr Harold Waters — ADDRESS: Box 287 Upper Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple Gunshot wounds to head and extremities

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 1:50AM 2-22-89 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject shot

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home — 21f. LOCATION STREET: 10132 Kings Bench Court, CITY OR TOWN: Ellicott City, COUNTY: Howard County, STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide XX, Undetermined manner ☐,

ACTUAL SIGNATURE: [signature] — TITLE (SPECIFY): Assistant M.D. MEDICAL EXAMINER — DATE SIGNED: 2-22-89

EXAMINER'S NAME (TYPE OR PRINT): James Kaplan, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 2-27-89 — 23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cem. — 23d. LOCATION CITY OR TOWN: Balto. — COUNTY — STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Joseph L. Russ 2222 W. North Ave

25a. DATE REC'D. BY REGISTRAR: FEB 27 1989 — 25b. REGISTRAR'S SIGNATURE: Lillian Brundell

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025051 MAR - 9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05320
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
LUTHER	Jacob	RODKEY	2	25	89	3:40 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	CAUCASIAN	3	10	11	77 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		Howard Co., MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
MOUNT AIRY	PLEASANT VIEW NURSING HOME	Electrician	Electric Prof.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Carroll	Taneytown	YES ☐ NO ☒	11937 Taneytown Pike/ 21787

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ira	-	Rodkey	Mary	-	Halter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	- - -	183-18-5191	Janet Joy /	4001 Kump Station Rd. Taneytown, md. 21787

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia — days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) chronic obstructive pulmonary disease — yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c): ASCVD, CHF, ~~Hypertension~~, Alzheimers, cancer uterus late

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/29, 19 87, to 2/25, 19 89, that (I) (we) last saw the deceased alive on 2/23, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 2/25/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Melvin J Gordon MD

22e. ADDRESS: 2000 Century Plaza Columbia MD 21044

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb. 28, 89	Grace United Church	Taneytown,	Carroll,	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SKILES FUNERAL HOME /TANEYTOWN, MD. 21787	136 E. BALTIMORE ST.	FEB 27 '89	Gina Davidson-Randall

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

023506 FEB 28

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005321

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Martha	C.	Shields	2	13	89	5 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	5	19	21	67 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Howard MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Elkridge	5985 Setter Dr.	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Howard	Elkridge	YES ☐ NO ☒	5985 Setter Dr. 21227

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Harry		Bowen	Lillie		Marley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		215-12-4734	Robert T. Shields, 5985 Setter Dr., Elkridge	Md. 21227

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Osteoporosis, Hypothyroidism

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
N/A	N/A	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐ N/A		N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 8 12, 19 88, to 2/10, 19 89, that (I) (we) last saw the deceased alive on 2/9, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Charles R Graham Jr	MD		2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C. GRAHAM	299 Frederick Rd Balt. Md 21228

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/17/89	Baltimore National	Balto. City		Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gary L. Kaufman	5695 Main St. Elkridge, Md. 21227	FEB 10 1989	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

0230688 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005322 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Grover	Middle: CLARENCE	Last: Shifflett	2a. DATE OF DEATH Month: 2 Day: 13 Year: 89
2b. HOUR: 5:00 M	3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH Month: 11 Day: 19 Year: 1906
6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD MD.
10. CITY OR TOWN OF DEATH: COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD CO. GEN. HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TEXTILE WORKER	12b. KIND OF BUSINESS OR INDUSTRY: DANIEL MILLS
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: CARROLL	13c. CITY OR TOWN: SYKESVILLE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 2209 LONGVIEW DR. 21784			
14. FATHER'S NAME First: SILAS Middle:	Last: SHIFFLETT	15. MOTHER'S MAIDEN NAME First: SUSAN Middle:	Last: MOWBRAY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 216-10-4915	17. INFORMANT ADDRESS:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic obstructive lung disease — 4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/8 19 89 to 2/13 19 89, that (I) (we) lost saw the deceased alive on 2/13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles E. Taylor M.D. — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles E. Taylor MD — 22e. ADDRESS: 2 Knoll North Drive, Columbia MD 21045

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 02-16-89	23c. NAME OF CEMETERY OR CREMATORY: GOOD SHEPHERD CEMETERY	23d. LOCATION CITY OR TOWN: ELLICOTT CITY COUNTY: HOWARD STATE: MD
24. FUNERAL DIRECTOR NAME: HAIGHT FUNERAL HOME ADDRESS: Box 195 Sykesville MD 21784	25a. DATE REC'D. BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: Davidson-Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

022744 FEB 15 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053223
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: Ruth	LAST: Sholar	2a. DATE OF DEATH MONTH DAY YEAR: 2-8-89	2b. HOUR: 2:10 AM	
3. SEX: FEMALE	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 7-4-22	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard Co. MD.		
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard Co. Gen. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Purchasing Dept.	12b. KIND OF BUSINESS OR INDUSTRY: Ft. Meade / Bend.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Howard	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 6409 Waterloo Rd. 21227	
14. FATHER'S NAME FIRST: George	MIDDLE: H.	LAST: Somerville	15. MOTHER'S MAIDEN NAME FIRST: Grace	MIDDLE: M.	LAST: Kirby
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 212226742	17. INFORMANT: Rose Marie Schaaf	ADDRESS: 8122 Forever Green Ct. Balto. MD. 21227	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hemorrhagic Shock	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Intra-abdominal Hemorrhage	24 hrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Pancreatic adenocarcinoma - metastatic	5 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD, Anemia, Protein-Calorie malnutrition, Ascites

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Sept, 19 88, to Feb, 19 89, that (I) (we) last saw the deceased alive on Feb 7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jon K. Mintzer	DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-8-89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jon K. Mintzer, MD	22e. ADDRESS: 10806 Hickory Ridge Rd Columbia MD 21044		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-11-89	23c. NAME OF CEMETERY OR CREMATORY: St. John's Lutheran Cem.	23d. LOCATION CITY OR TOWN: Pfeiffers Crn.	COUNTY: Howard STATE: Md.
24. FUNERAL DIRECTOR NAME: SLACK FUNERAL HOME	ADDRESS: Box 268 Ellicott City, MD 21043	25a. DATE REC'D. BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 05324

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE E. LAST Sidlowski

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR: 2-8-89

2b. HOUR: M

3. SEX: M

4. RACE: Cauc

5. DATE OF BIRTH: MONTH DAY YEAR: July 23, 1960

6. AGE (IN YEARS LAST BIRTHDAY): 28 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR: 2-8- 1989

2d. HOUR: 8:50 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.

10. CITY OR TOWN OF DEATH: Ellicott City

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9050 Red Branch Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Construction

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Howard

13c. CITY OR TOWN: Ellicott City

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: 1301 Summitt Ave 21228

14. FATHER'S NAME: FIRST James E. MIDDLE LAST Sidlowski

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE LAST McGillin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-86-1359

17. INFORMANT: James Sidlowski ADDRESS: 1301 Summitt Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hanging

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 2-8-89

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Subject hanged self

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Warehouse

21f. LOCATION STREET CITY OR TOWN COUNTY STATE: 9050 Red Branch Road, Ellicott City, Howard County, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Margarita Korell TITLE (SPECIFY): Assistant M.D. MEDICAL EXAMINER DATE SIGNED: 2-8-89

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/11/89

23c. NAME OF CEMETERY OR CREMATORY: Greenmount

23d. LOCATION CITY OR TOWN COUNTY STATE: Baltimore Md

24. FUNERAL DIRECTOR NAME ADDRESS: Sterling Ashton Funeral Estate, P.A. 736 Edmondson Ave 21228

25a. DATE REC'D. BY REGISTRAR: FEB 10 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023271 FEB 2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05325
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: A.	LAST: SKIPPER	2a. DATE OF DEATH MONTH: 02	DAY: 15	YEAR: 89	2b. HOUR: 11:05pm
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 02 DAY: 20 YEAR: 94	6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN.:	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY			MD.
10. CITY OR TOWN OF DEATH: COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): LORIEN NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: HOWARD	13c. CITY OR TOWN: COLUMBIA	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 5870 A3 THUNDER HILL ROAD 21045		
14. FATHER'S NAME FIRST: JOHN	MIDDLE: OSCAR	LAST: MARKLE	15. MOTHER'S MAIDEN NAME FIRST: MERTIE	MIDDLE:	LAST: JOHNSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): ------	16b. SOCIAL SECURITY NO.: 219-54-2744	17. INFORMANT: PHYLLIS BROWER 5870 A3 THUNDERHILL ROAD	ADDRESS: COLUMBIA, MD 21045		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-pulmonary arrest	15 min
DUE TO, OR AS A CONSEQUENCE OF (b)	MV Hyde CVAS	2 years.
DUE TO, OR AS A CONSEQUENCE OF (c)	Senile Dementia	2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital) attended the deceased from ____, 19 1987, to 2/16, 19 89, that (I) (we) last saw the deceased alive on 2/16, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. CHARLES SHEEHAN

22e. ADDRESS: ELLICOTT CITY, MD 10298-B BALTIMORE NATIONAL PIKE 21043

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/21/89	23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.	23d. LOCATION CITY OR TOWN: ARLINGTON	COUNTY / STATE: VIRGINIA
24. FUNERAL DIRECTOR NAME: LEROY H & RUSSELL C WITZKE FUNERAL HOME ADDRESS: 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045		25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Taylor Rodgers	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

22841 FEB 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053256
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
JOSEPH	VINCENT	SWEENEY SR.	2	11	89 / 4:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	2	25	1907	81 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
WASHINGTON D.C.	U.S.A.		HOWARD COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
COLUMBIA	10799 HICKORY RIDGE RD. APT. 221	CIRCULATION MANAGER	NEWSPAPER

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	HOWARD	COLUMBIA	YES ☐ NO ☒	COLUMBIA, MD 21044 10799 HICKORY RIDGE RD. APT. 221

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN	F.	SWEENEY	ADA	CECILIA	BRECHT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	578-09-9868	KATHLEEN SLOAN	SAME AS 13e.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic pancreatic cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/11, 19 88, to 11/16, 19 88, that (I) (we) last saw the deceased alive on 11/16, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dwyer, Steve	11055 Little Patuxent Parkway

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	2/12/89	WESTVIEW CREMATORY	CATONSVILLE MARYLAND

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
5555 TWIN KNOLLS RD. COLUMBIA, MD. 21045 LEROY M. & RUSSELL C. WITZKE FUNERAL HOME	FEB 14 1989	Sheila Davidson-Randall

BP

DHMH-16 30M 2/80 (VRA 15, 4)

024383 MAR-2 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 REG. NO. 05327

1. DECEASED NAME (TYPE OR PRINT): FIRST ERNEST MIDDLE ALTON LAST TOMAI
7a. DATE OF DEATH: MONTH 1 DAY 17 YEAR 89
7b. HOUR: 9:40 A M
3. SEX: MALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MONTH 11 DAY 27 YEAR 07
6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW JERSEY
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD MD.
10. CITY OR TOWN OF DEATH: COLUMBIA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD CO. GEN. HOSP.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED
12b. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD.
13b. COUNTY: HOWARD
13c. CITY OR TOWN: ELLICOTT CITY
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: 3355 N. CHATHAM R.D. # F 21043

14. FATHER'S NAME: FIRST ANTONIO MIDDLE LAST TOMAI
15. MOTHER'S MAIDEN NAME: FIRST CARMELA MIDDLE LAST BARLETTA
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
16b. (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 197037356
17. INFORMANT: MONA TOMAI ADDRESS: 3355 N. CHATHAM RD # F ELLICOTT CITY MD 21043

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): METASTATIC SQUAMOUS CELL CARCINOMA — MONTHS
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: PERFORATION OF SMALL BOWEL BY METASTASES OF CARCINOMA

19a. DATE OF OPERATION: JAN 2, 89
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: PERFORATION OF SMALL BOWEL
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from JAN 2 19 89 to JAN 17 19 89, that (I) (we) last saw the deceased alive on JAN 16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W.E. Signor M.D. DEGREE: M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 1/17/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): W.E. SIGNOR M.D.
22e. ADDRESS: 2850 N. RIDGE RD. ELLICOTT CITY, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION
23b. DATE: 1-18-89
23c. NAME OF CEMETERY OR CREMATORY: WESTVIEW
23d. LOCATION: CITY OR TOWN CATONSVILLE COUNTY BALTO STATE MD

24. FUNERAL DIRECTOR: NAME HARRY H. WITZKE INC. ELLICOTT CITY MD ADDRESS 4112 COLUMBIA RD 21043
25a. DATE RECD. BY REGISTRAR: JAN 20 89
25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

BP 5

DHMH-16 50M 1/81 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

J22743 FEB 15 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B12 REG. NO. 005328

1. DECEASED NAME (TYPE OR PRINT): FIRST RAYMOND MIDDLE R LAST WELLS

2a. DATE OF DEATH: MONTH 2 DAY 2 YEAR 89 — 2b. HOUR 12:30 PM

3. SEX: MALE — 4. RACE: WHITE — 5. DATE OF BIRTH: MONTH 03 DAY 19 YEAR 1906 — 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD.

10. CITY OR TOWN OF DEATH: COLUMBIA — 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD CO. GEN. HOSP. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ADMINISTRATION — 12b. KIND OF BUSINESS OR INDUSTRY: STATE ROADS

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: HOWARD — 13c. CITY OR TOWN: ELLICOTT CITY — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE: 4866 MONTGOMERY RD. 21043

14. FATHER'S NAME: FIRST WILLIAM MIDDLE LAST WELLS — 15. MOTHER'S MAIDEN NAME: FIRST LEE MIDDLE ANNA LAST SULLIVAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): — — 16b. SOCIAL SECURITY NO.: 212-03-3541-A — 17. INFORMANT: EVELYN WELLS — ADDRESS: 4866 MONTGOMERY RD. ELLICOTT CITY, MD 21043

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST — Instalan

DUE TO, OR AS A CONSEQUENCE OF (b): SEPSIS — Days

DUE TO, OR AS A CONSEQUENCE OF (c): ARTHROSCLEROSIS — Years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Colon carcinoma, Diabetes-Mellitus, renal failure.

19a. DATE OF OPERATION: 1/13/89 — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: COLON CARCINOMA. — 20a. AUTOPSY? YES ☐ NO ☒ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 19 85 to Febr 2 19 89, that (I) (we) last saw the deceased alive on Febr 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. LEONE, MD — 22e. ADDRESS: 11055 Little Patuxent Pkwy, Columbia, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 6 FEB 89 — 23c. NAME OF CEMETERY OR CREMATORY: GOOD SHEPHERD CEM. — 23d. LOCATION CITY OR TOWN: ELLICOTT CITY — COUNTY: HOWARD — STATE: MD.

24. FUNERAL DIRECTOR NAME: [signature] — ADDRESS: SLACK FUNERAL HOME ELLICOTT CITY, MD. 21043 — 25a. DATE REC'D. BY REGISTRAR: FEB 15 1989 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

022760 FEB 15 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005327

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Raymond	MIDDLE: B	LAST: Whetzel	2a. DATE OF DEATH MONTH: 2	DAY: 12	YEAR: 89
2b. HOUR: 5 05 PM					
3. SEX: Male	4. RACE: W	5. DATE OF BIRTH MONTH: 2	DAY: 12	YEAR: 08	
6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD MD.		
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Lorien Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: Howard	13c. CITY OR TOWN: Ellicott City	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 4676 Woodland Rd 21043	
14. FATHER'S NAME FIRST: George	MIDDLE: W.	LAST: Whetzel	15. MOTHER'S MAIDEN NAME FIRST: Susie	MIDDLE:	LAST: Delawder
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-18-6435	17. INFORMANT: Wm. Brandt	ADDRESS: 4676 Woodland Rd. 21043	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO, OR AS A CONSEQUENCE OF
(b): Acute cerebrovascular accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Acute Bronchitis, CVA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-16- 19 84 to 2-12- 19 89 that (I) (we) last saw the deceased alive on 2-12- 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Krishna P. Kumar	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-12-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. KRISHNA PKUMAR	22e. ADDRESS: 10798A Hickory Ridge Rd Columbia MD 21044	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-15-89	23c. NAME OF CEMETERY OR CREMATORY: Linthicum Chapel Cem.	23d. LOCATION CITY OR TOWN: CLARKSVILLE	COUNTY / STATE
24. FUNERAL DIRECTOR NAME / ADDRESS: SIACK F.H. Box 268 Ellicott City 21043	25a. DATE REC'D. BY REGISTRAR: FEB 13 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024125 FEB 29 09 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05330 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or any traumatic event, the medical examiner must be notified of case.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: GEAMETRUS (Geametrus) MIDDLE: S. LAST: WILLIAMS (Williams)				2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 20, 1989	2b. HOUR: 11:35P M
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: APRIL 14, 1920		6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD.	
10. CITY OR TOWN OF DEATH: COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: HOWARD	13c. CITY OR TOWN: COLUMBIA	13d. INSIDE CITY LIMITS? YES [ ] NO [XX]	13e. STREET ADDRESS / ZIP CODE: 8770 CLOUDLEAP CT. APT. T3 21045	
14. FATHER'S NAME FIRST: WILLIAM MIDDLE: LAST: BRIGGS				15. MOTHER'S MAIDEN NAME FIRST: AUGUSTUS MIDDLE: LAST: BIBBS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 289-18-8469		17. INFORMANT: CHARLES E. WILLIAMS ADDRESS: 8770 CLOUDLEAP CT., APT. T3 COLUMBIA, MD. 21045	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Bilateral pleural Effusions
DUE TO, OR AS A CONSEQUENCE OF (c): Colonic Adenocarcinoma. stage D
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic anemia, liver failure, Cardiac arrhythmia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Sept, 19 86, to Feb, 19 89, that (I) (we) last saw the deceased alive on Feb 20, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jon K. Minfend	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/21/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J.W K. Minfend MD	22e. ADDRESS: 10806 Hickory Ridge Rd, Columbia MD 21044		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/23/89	23c. NAME OF CEMETERY OR CREMATORY: MARYLAND VETERANS, GARRISON FOREST-OWINGS MILLS	23d. LOCATION CITY OR TOWN: COUNTY: MARYLAND	
24. FUNERAL DIRECTOR NAME: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. ADDRESS: 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045		25a. DATE REC'D. BY REGISTRAR: FEB 22 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

024043 FEB 23 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05331 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of other.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Rufus	MIDDLE: A.	LAST: Williams	2a. DATE OF DEATH MONTH: 2	DAY: 20	YEAR: 89	2b. HOUR: 9:00 A.M.
3. SEX: M	4. RACE: B 2	5. DATE OF BIRTH MONTH: 4	DAY: 27	YEAR: 24	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.C.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard Co. MD.			
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bethlehem Steel	12b. KIND OF BUSINESS OR INDUSTRY: Tool + Die			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Howard	13c. CITY OR TOWN: Ellicott City	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 8781 Town + Country Blvd. 21042		
14. FATHER'S NAME FIRST: Frank	MIDDLE	LAST: Williams	15. MOTHER'S MAIDEN NAME FIRST: Cattie	MIDDLE	LAST: McNair	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES) NO OR UNKNOWN (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 239-26-0728	17. INFORMANT: Catherine Williams Blair	ADDRESS: Louisville, Ky 40218 4910 Shumate CT.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Probable Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c): _____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours / 10 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension; Hx of prostate surgery

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Dec 7 1988 to Feb 20 19 89, that (I) (we) last saw the deceased alive on Feb 17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ELIJAH SAUNDERS, M.D.

22e. ADDRESS: 419 W. REDWOOD ST. BALTO. MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-24-89	23c. NAME OF CEMETERY OR CREMATORY: Garrison Forest	23d. LOCATION CITY OR TOWN: Owings Mills COUNTY: Md. STATE	
24. FUNERAL DIRECTOR NAME / ADDRESS: James A. Morton & Sons 1701 Laurens St.	25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05332
REG. NO.

025244 MAR 14 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	John	MIDDLE William	LAST Bigelow Sr.	2a. DATE OF DEATH MONTH DAY YEAR	February 22, 1989
2b. HOUR	4:05A				M
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	December 4, 1914
6. AGE (IN YEARS LAST BIRTHDAY)	74 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	AMerican	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Kent MD.				
10. CITY OR TOWN OF DEATH	Chestertown,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Kent & Queen Anne's Co. Hospitol	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	INS. Farmer
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Kent	Chestertown	YES [ ] NO [X]	RFD Pomona 21620

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Pierson	Bigelow		Emma	Joiner	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		220 34 9560	Mary Bigelow	RFD Pomona 21620 Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Obstructive Lung Dsease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

Cor Pulmonale · Atrial Fibrillation

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/14, 19 89, to 2/22, 19 89, that (I) (we) last saw the deceased alive on 2/22, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
George M Young	MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GEORGE M. YOUNG	Kent and Queen Anne's Hosp. Chestertown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb 24, 1989	St. Paul's Cemetery	Chestertown, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
J. Willis Wells	J. Willis Wells Chestertown, Md.	FEB 23 '89	Julia Davidson-Randall

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

024637 MAR-3 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05333
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Thomas	MIDDLE: Layton	LAST: BINEBRINK	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR: Feb. 16, 1989	2b. HOUR: 12:30 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 27, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: February 16, 19 89	2d. HOUR: 1:40 P.M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.		
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): residence, 204 Waldo Drive, Byford Heights	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer(ret.)	12b. KIND OF BUSINESS OR INDUSTRY: Farming		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Maryland	13b. COUNTY: Kent	13c. CITY OR TOWN: Chestertown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 204 Waldo Drive, Byford Heights, 21620	
14. FATHER'S NAME FIRST: Thomas	MIDDLE: Henry	LAST: Binebrink	15. MOTHER'S MAIDEN NAME FIRST: Ida	MIDDLE: Mae	LAST: Dulin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219-07-7099	17. INFORMANT ADDRESS: 509 Kent St., Byford Heights; Ms. Florence I. Towsend, Chestertown, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Massive shotgun wound to the head

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2620

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES [ ] NO [X]
20a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	20b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 12:30 P.M. 2-16 19 89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): self inflicted shotgun wound to head	
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home	21f. LOCATION STREET: 204 Waldo Drive, CITY OR TOWN: Chestertown, COUNTY: Kent, STATE: Maryland	

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Robert W. Farr M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-17-89

EXAMINER'S NAME (TYPE OR PRINT): Robert W. Farr, M.D. ADDRESS: Chestertown, Maryland 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 20, 1989	23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery	23d. LOCATION CITY OR TOWN: Centreville, COUNTY: Q.A.Co., STATE: Md.	
24. FUNERAL DIRECTOR NAME: Barton Funeral Home; ADDRESS: James H. Barton, Jr., Centreville, Md. 21617		25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall	

07/84 25M BP 5

DHMH - 17 (VR A15 ME (5))

024933 MAR 8 9

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05334

1. DECEASED NAME (TYPE OR PRINT): FIRST Marion; MIDDLE; LAST BLAKE

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 2 DAY 21 YEAR 19 89

2b. HOUR 1 A M

3. SEX: Male

4. RACE: Black

5. DATE OF BIRTH: MONTH Dec. DAY 27 YEAR 1937

6. AGE (IN YEARS LAST BIRTHDAY) 51/52 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR 2/21/89 19

2d. HOUR 7 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.

10. CITY OR TOWN OF DEATH: Sassafras

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): At Home Caldwell Cor. Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Handyman

12b. KIND OF BUSINESS OR INDUSTRY: Odd Jobs

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Kent

13c. CITY OR TOWN: Sassafras

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Caldwell Corner Road 2637

14. FATHER'S NAME: FIRST Marion; MIDDLE; LAST Blake Sr.

15. MOTHER'S MAIDEN NAME: FIRST Ethel; MIDDLE XXXXX; LAST Clark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): NO

16b. SOCIAL SECURITY NO.: 219-34-0034

17. INFORMANT: Ethel C. Blake ADDRESS Caldwell Cor. Rd. Sassafras, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Throat Metastatic to Cancer

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Mo

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Robt W. Farr M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2/21/89

EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr M.D. Robert W. Farr ADDRESS Chestertown, Kent Cty Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/25/1989

23c. NAME OF CEMETERY OR CREMATORY: Dales Cemetery

23d. LOCATION CITY OR TOWN: Middletown COUNTY: New Castle STATE: Del.

24. FUNERAL DIRECTOR NAME ADDRESS: Gary B. Fellows Box 270 Millington, Md 21651

25a. DATE REC'D BY REGISTRAR: FEB 21 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 2. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP 2

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 89 005335

1. DECEASED NAME (TYPE OR PRINT): First: Mabel; Middle: Elizabeth; Last: Blickenstaff

2a. DATE OF DEATH: Month Day Year: 2-15-89

2b. HOUR: 1:10 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Month Day Year: 12-16-01

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS: Hours, Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Centreville, MD

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.

10. CITY OR TOWN OF DEATH: Chestertown,

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kent & Queen Anne's Co Hosp. INC

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Q.A.

13c. CITY OR TOWN: Chester

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: 21619

14. FATHER'S NAME: First Middle Last: Charles Wilmer Moore

15. MOTHER'S MAIDEN NAME: First Middle Last: Sarah Elizabeth (nee) Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 214-52-2331

17. INFORMANT ADDRESS: Bessie Mitchell, 4129 Audrey Ave., Baltimore, MD 21225

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b): pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 3-3-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Michael Bienefeld

22e. ADDRESS: Medical Building, Chestertown, MD 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02/18/89

23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery

23d. LOCATION: CITY OR TOWN: Centreville COUNTY: Q.A. STATE: MD

24. FUNERAL DIRECTOR NAME ADDRESS: Tom Helfenbein Funeral Home, Chester, MD 21619

25a. DATE REC'D. BY REGISTRAR: MAR 13 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

022931 FEB 15 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005336 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 4. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Margaret, A. Bostic	2a. DATE OF DEATH MONTH DAY YEAR	2-4-1989	2b. HOUR	4:40 A M
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	10-15-1913
6. AGE (IN YEARS LAST BIRTHDAY)	75 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	Amer. USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Kent MD.				
10. CITY OR TOWN OF DEATH	Chestertown,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Kent & Queen Anne's Co. HOspitol INC.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Homemaker
12b. KIND OF BUSINESS OR INDUSTRY	Home				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Pennsylvania	Delaware	Wallingford	YES ☒ NO ☐	308 Hastings Avenue 19086

14. FATHER'S NAME FIRST / MIDDLE / LAST	William Noble Sipple, Sr.	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Mary Ann Jones
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	no	16b. SOCIAL SECURITY NO.	182-18-2353
17. INFORMANT / ADDRESS	Gary A. Sipple Wilmington, DE 19810		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Pulmonary Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction — 11 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cardiogenic Shock; Ischemic Cardiomyopathy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 1/24, 19 89, to 2/4, 19 89, that (I) (we) last saw the deceased alive on 2/4 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
George M Young	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GEORGE M. YOUNG	Kent and Queen Anne's Hosp. Chestertown, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-7-89	Sudlersville Cem.	Sudlersville QA MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Fleegle-Helfenbein Funeral Home, Greensboro, MD	FEB 13 1989	Gloria Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024934 MAR-8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05337 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harold	MIDDLE: M.	LAST: Everett, Sr.	2a. DATE OF DEATH MONTH DAY YEAR: February 19, 1989	2b. HOUR: M	
3. SEX: Male	4. RACE: Cauc.	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 8, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): McGinnis Corner	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.		
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Longfellow Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farming	12b. KIND OF BUSINESS OR INDUSTRY: Farming		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
PA	Chester	Oxford	YES ☒ NO ☐	Old Limestone Road 99999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel	J.	Everett	Susie		Whitlock

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A	N/A	221-14-9501	Ellen Bramble	Rt. 4 Box 412 Chestertown MD 21620

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of Prostate with Metastasis
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/13, 19 89, to 2/19, 19 89, that (I) (we) last saw the deceased alive on ____, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
K.K. Whan	MD. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
KIN KUE WAN, MD.	216 High St, Chestertown, Md-21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/22/89	Asbury Cemetery	Millington, Kent MD

24. FUNERAL DIRECTOR NAME, ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gary B. Fellows, Box 270, Millington, MD 21651	FEB 22 '89	Julia Davidson-Kendall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH-16 50M 1/81 (VRA 15, 4)

024931 MAR-8 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005338 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Alice Marybelle Gee			2a. DATE OF DEATH MONTH DAY YEAR: February 9, 1989	2b. HOUR: 5:35PM M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: April 21, 1950	6. AGE (IN YEARS LAST BIRTHDAY): 38 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.	
10. CITY OR TOWN OF DEATH: CHestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kent ANd Queen Annes Hospital Inc		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Factory	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Kent	13c. CITY OR TOWN: Chestertown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 502 Calvert Height 21620
14. FATHER'S NAME FIRST / MIDDLE / LAST: Morris Blake Sr.			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Thelma E. Blake	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 212-56-1436	17. INFORMANT: Miss, Vernite Blake	ADDRESS: R.F.D. 2 Box 4-B Chestertown, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): metastatic cervical carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-16-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael Bienenfeld M.D. 22e. ADDRESS: Chestertown, Maryland 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/14/1989	23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery	23d. LOCATION CITY OR TOWN: R.F.D. Chestertown, Md. COUNTY: Kent STATE
24. FUNERAL DIRECTOR NAME: [signature]	ADDRESS: Chestertown, Md.	25. DATE REC'D BY REGISTRAR: FEB 21 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

024102 FEB 2289

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 5339

DECEASED NAME (TYPE OR PRINT): First: Wesley; Middle: Owen; Last: Henry

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — Month/Day/Year: 2-16-89

2b. HOUR: M

3. SEX: Male

4. RACE: Black

5. DATE OF BIRTH: Month/Day/Year: Nov. 11, 1951

6. AGE (IN YEARS LAST BIRTHDAY): 37 YRS.

IF UNDER 1 YR. — MONTHS / DAYS

IF UNDER 24 HRS. — HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month/Day/Year: 2-16-89

2d. HOUR: 6:30 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Kent County MD.

10. CITY OR TOWN OF DEATH: Chestertown

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kent and Queen Anne Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Kent

13c. CITY OR TOWN: Chestertown

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: R.F.D.#3 21620

14. FATHER'S NAME: First: James; Middle: I.; Last: Henry Sr.

15. MOTHER'S MAIDEN NAME: First: Mary; Middle: E.; Last: Graves

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

16b. IF YES, GIVE WAR OR DATES:

16b. SOCIAL SECURITY NO.: 219-56-8211

17. INFORMANT ADDRESS: Mrs. Mary E. Graves Chestertown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple stab wounds

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M./P.M. MONTH DAY YEAR: 5:30PM 2-16-89

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject stabbed

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION: STREET: Washington Park, CITY OR TOWN: Chestertown, COUNTY: Kent County, STATE: MD

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide XX, Undetermined manner ☐,

ACTUAL SIGNATURE: Mario F. Golle Jr M.D.

TITLE (SPECIFY): Assistant MEDICAL EXAMINER

DATE SIGNED: 2-17-89

VC

EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr. M.D.

ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/22/1989

23c. NAME OF CEMETERY OR CREMATORY: Haddaway Chapel

23d. LOCATION: CITY OR TOWN: R.F.D. Chestertown, Md. COUNTY: Kent STATE:

24. FUNERAL DIRECTOR NAME: Kenneth Wolfe ADDRESS: Chestertown, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 21 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, OMITTING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

025253 MAR 14 89

1 - FOR STATE REGISTRAR

REG. NO. 89 005340

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 20 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last	William Edward Hutchins Sr.	2a. DATE OF DEATH Month Day Year	2-27-1989	2b. HOUR	7:37 AM
3. SEX	Male	4. RACE	Black	5. DATE OF BIRTH Month Day Year	1-22-1928
6. AGE (IN YEARS LAST BIRTHDAY)	61 YRS.	IF UNDER 1 YEAR Months / Days		IF UNDER 24 HRS Hours / Min.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Kent MD.				
10. CITY OR TOWN OF DEATH	Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Kent & Queen Anne's Co. Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Labor
12b. KIND OF BUSINESS OR INDUSTRY	Various				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Kent	13c. CITY OR TOWN	Chestertown
13d. INSIDE CITY LIMITS? YES ☐ NO ☐		13e. STREET ADDRESS	Route #3 Box 1-A 21620		
14. FATHER'S NAME First / Middle / Last	William Albert Hutchins	15. MOTHER'S MAIDEN NAME First / Middle / Last	Mary Esther Raisin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	(IF YES, GIVE WAR OR DATES)	WW11	16b. SOCIAL SECURITY NO	213-22-7333
17. INFORMANT	Mrs. Louise Hutchins	ADDRESS	R.F.D.#3 Box 1-A Chestertown, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Chronic obstructive pulm disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-17 19 89 to 2-27 19 89, that (I) (saw) last saw the deceased alive on 2-26 19 89, and that in (my) (opinion) death occurred on the date and hour and from the causes stated above. (I) (examined) (did not) view the body after death.

22b. SIGNATURE: Eric Ciganek M.D. — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Eric Ciganek M.D. — 22e. ADDRESS: 109 S. Commerce St. Centreville, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	2-4-1989	23c. NAME OF CEMETERY OR CREMATORY: Janes United Meth. — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Chestertown, Kent, Md.
24. FUNERAL DIRECTOR NAME	Kenneth Wells	ADDRESS	Chestertown, Maryland	25a. DATE REC'D BY REGISTRAR: MAR 01 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 11

DHMH-16 25M
(VRA 15, 4) 1/79

023107 FEB 1789

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05341
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and sent to the local registrar. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If "Autopsy" is marked on item 18 it means only injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Anna	Emmart	Makosky	February 2, 1989	3:15a M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	July 15, 1905	83 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore, MD	U.S.A.		Kent County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown	Magnolia Hall Nursing Home	Housewife			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Kent	Rock Hall	YES ☐ NO ☐	Rt. 1 Box 321 21661

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
John W. Emmart	ELLEN E, Wetherstein

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		215-22-7014A	Bettylou M. Lockwood, 16 Greenwood Ave.	Baltimore, MD 21206

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) respiratory accest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) cose bravesculor accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED
	MD		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Michael Bienefeld	Medical Building, Chestertown, MD 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	02/06/89	Dulaney Valley Cemetery	Baltimore Balt. MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tom Helfenbein Funeral Homes, Rock Hall, MD 21661	FEB 3 '89	Julia Davidson-Randall

BP 5

DHMH - 16 60M 7/84
(VRA 15, 4)

24870 MAR-8 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 05342

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached, folded and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If hernia is marked on Item 18 as any injury, or other traumatic event, the medical examiner must be notified above.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Margaret	Mary	MULLIKIN	February	21,	1989 / 10:50 PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	July 19, 1899	89 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Kent MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown	Magnolia Hall Nursing Home		Clerk (retired)	Retail Store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	BaltimoreCity	Baltimore	YES ☒ NO ☐	1 East University Pkwy, 21218	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Eugene	Vincent	Mullikin	Alexandria	Emmaline	Weedon
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT Nephew	ADDRESS R.D. 4, Box 290	
No		214-20-3937	John E. Mullikin,	Cambridge, Md. 21613	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Severe Respiratory Infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from 11-25, 19 86, to 2-21, 19 89, that (I) (we) last saw the deceased alive on 2-15, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2-22-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.	22e. ADDRESS 424 High Street Chestertown, Maryland 21620	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb. 22, 1989	Cedar Hill Cemetery	Suitland, PrinceGeorge's, Md.
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James H. Barton, Jr., Barton Funeral Home, Centreville, Md. 21617		FEB 22 '89	Gisha Davidson Randall

BP 24

DHMH - 16 60M 7/84
(VRA 15, 4)

023965 FEB 23 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005343

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	FREDERICK AUGUST MYERS	2a. DATE OF DEATH MONTH DAY YEAR	February 12, 1989	2b. HOUR	1:10 A M
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	July 8, 1907
6. AGE (IN YEARS LAST BIRTHDAY)	81 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Balto. Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Kent County MD.				
10. CITY OR TOWN OF DEATH	Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Magnolia Hall Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Sales Person Department Store
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Kent	Rock Hall	YES ☐ NO ☐	P.O. Box # 9 21661

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
August F. Myers	Josie Ann Ostendarp		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW 2	215 07 3901	Ivah M. Strong Rock Hall, Md. 21661

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. — 4 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

URINARY TRACT INFECTION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11-4, 19 88, to 2-12, 19 89, that (I) (~~we~~) last saw the deceased alive on 2-11-, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE Harry Paul Ross MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross — 22e. ADDRESS Chestertown, Maryland 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	February 14, 1989	Moreland Memo. Park	Baltimore, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
J. Willis Wells	J. Willis Wells Chestertown, Md.	FEB 13 '89	Julia Davidson-Randall

BP 6+2

DHMH - 16 60M 7/84 (VRA 15, 4)

024692 MAR -3 09 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 05344

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. A medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Cammie	Howard	Neal	February	12,	1989 / M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male	Black	July 13, 1924	64 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Kent MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Chestertown	Kent and Queen Anne's Hosp.	Labor	Various

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Kent	Chestertown	YES ☐ NO ☐	110 Prospect St.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Cammie	F.	Neal	Maggie		Oliver

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	217-16-3703	Mrs. Margaret Robinson	Chestertown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
(1) Congestive Heart Failure (2) Chronic Renal Failure (3) DM.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/15, 19 87, to 2/11, 19 89, that (I) (we) last saw the deceased alive on 2/12, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	M.D.		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Kin Kue Wun	216 High St, Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/18/1989	Janes United Meth.	Chestertown	Kent	Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
[signature]	Chestertown, Md.	FEB 16 89	Gina Davidson-Randall

BP 10

DHMH-16 25M
(VRA 15, 4) 1/79

124932 MAR -8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053455
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Addie	MIDDLE: Louise	LAST: Skinner	2a. DATE OF DEATH MONTH DAY YEAR: February 17, 1989	2b. HOUR: M	
3. SEX: Female	4. RACE: Cauc.	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 19, 1891	6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.		
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Magnolia Hall Nursing Ctr.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Defense Assembly	12b. KIND OF BUSINESS OR INDUSTRY: Munisions		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Q.A.	13c. CITY OR TOWN: Sudlersville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 2D, Dogwood Village	
14. FATHER'S NAME FIRST: George	MIDDLE	LAST: Watling	15. MOTHER'S MAIDEN NAME FIRST: Ella	MIDDLE	LAST: Reed
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 215-20-2227	17. INFORMANT: Sue Comegys-	ADDRESS: Chestertown, MD 21620	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory Collapse — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): Disease — 4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): previous stroke

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6 19 67 to 2/17 19 89 that (I) (we) last saw the deceased alive on 2/17 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C. Baumann	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/20/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): C. Gottfried Baumann, M.D.	22e. ADDRESS: Medical Building-Chestertown, MD. 21620		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/20/89	23c. NAME OF CEMETERY OR CREMATORY: Crumpton Cemetery	23d. LOCATION CITY OR TOWN: Crumpton	COUNTY: Q.A. STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: Gary B. Fellows, Box 270, Millington, MD 21651		25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 4

DHMH - 16 50M 1/81
(VRA 15, 4)

Item #5 Film G648 2/21/89 cg

023399 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 9 REG. NO. 0 5 3 4 6

1. DECEASED NAME (TYPE OR PRINT) FIRST: Josephine	MIDDLE: Davis	LAST: Voshell	2a. DATE OF DEATH MONTH DAY YEAR: 02-06-89	2b. HOUR: M	
3. SEX: Female	4. RACE: Cauc.	5. DATE OF BIRTH MONTH DAY YEAR: 07-28-~~13~~ 12	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Sassafras, Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.		
10. CITY OR TOWN OF DEATH: Millington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): (at home) Cypress Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Kent	Millington	YES [X] NO [ ]	P.O.Box 2165 Cypress St.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
M.	Earle	Davis	Lilly		Pearce

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
n/a	n/a	212-28-6866	Herman Voshell Jr. (son) Millington, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Circulatory collapse	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD	year
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M./P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 1 10 19 90, to 2 16 19 89, that (I) (we) last saw the deceased alive on 1 30 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
C.G. Baumann	MD	[ ] [X] [ ]	2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C.G. BAUMANN	CHESTERTOWN, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-10-89	Asbury Cemetery	Millington Kent Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gary B. Fellows Box 370 Millington, Md.	FEB 9 89	Gina Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____ B

DHMH - 16 50M 1/81 (VRA 15, 4)

022086 FEB - 9 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05347 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mollie	MIDDLE	LAST: Abramson	2a. DATE OF DEATH MONTH/DAY/YEAR: 2/4/89	2b. HOUR: 655 P M	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH/DAY/YEAR: 7/17/03	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Potomac	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 11520 Gainsborough Road (20854)	
14. FATHER'S NAME FIRST: Morris	MIDDLE	LAST: Frank	15. MOTHER'S MAIDEN NAME FIRST: Fannie	MIDDLE	LAST: Lefkowitz
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): --------	16b. SOCIAL SECURITY NO.: 077-18-2497	17. INFORMANT ADDRESS: Bernice Schnall; Daughter; 11625 Deborah Drive Potomac, Md. 20854		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c): HEMMORHAGIC SHOCK
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ANEMIA, UPPER GASTROINTESTINAL HEMMORRHAGE, SENILE DEMENTIA, MYOCHOLIC INFARCT

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from JUNE 1987 to 2/4 1989, that (I) we) last saw the deceased alive on 2/4 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): IRVING MIRUS, MD 22e. ADDRESS: 5413 CEDAR LANE BETHESDA, MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/8/89	23c. NAME OF CEMETERY OR CREMATORY: New Montefiore Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Pinelawn, L.I., New York	
24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852	25a. DATE REC'D. BY REGISTRAR: FEB 7 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall		

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024093 FEB 2 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05348
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST ANNA MIDDLE O. LAST ADEN

2a. DATE OF DEATH: MONTH 2 DAY 7 YEAR 89

2b. HOUR 3:20 PM

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH: MONTH 8 DAY 19 YEAR 01

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NORTH DAKOTA

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TEACHER MONTGOMERY CTY SCHOOLS

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: SILVER SPRING

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 1609 SHERWOOD ROAD 20902

14. FATHER'S NAME: FIRST OLIE MIDDLE LAST KNUTSON

15. MOTHER'S MAIDEN NAME: FIRST MARIE MIDDLE LAST OLSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-44-1407

17. INFORMANT ADDRESS: DEAN ADEN/HUSBAND/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO-PULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 MIN

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY HEART DISEASE — 15 YRS

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: AORTIC STENOSIS, CEREBRO VASCULAR ACCIDENT RECENT HEART SURGERY

19a. DATE OF OPERATION: 1/26/89

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: SICK SINUS - PACEMAKER

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-6 19 73 to 2-7 19 89, that (I) (we) last saw the deceased alive on 2-6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE AND DEGREE: David Goldenberg MD

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAVID GOLDENBERG MD

22e. ADDRESS: 9801 GEORGIA AVE SILVER SPRING, MD 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: FEB 9, 1989

23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY

23d. LOCATION: CITY OR TOWN ROCKVILLE — COUNTY MONTGOMERY — STATE MD

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR.
ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25d. DATE REC'D BY REGISTRAR: FEB 13 '89

25e. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

023314 FEB 21 - 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053499 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: NAFISA	MIDDLE: AHMED	LAST: ALLAM	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 10, 1989	2b. HOUR: 11:55PM	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 16 1926	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): EGYPT	7b. CITIZEN OF WHAT COUNTRY?: EGYPT	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY:		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: EGYPT	13b. COUNTY: EGYPT	13c. CITY OR TOWN: CAIRO	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: U 99999
14. FATHER'S NAME FIRST: AHMED	MIDDLE: ALLAM	LAST:	15. MOTHER'S MAIDEN NAME FIRST: NABAWIA	MIDDLE: HAMZA LAST:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: None	17. INFORMANT ADDRESS: AHMED YOSRI ZAKI 2308 TRACY PL, WASHINGTON, D.C. 20008	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): COLON CANCER

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from December 26 19 88, to February 10 19 89, that (I) (~~we~~) last saw the deceased alive on February 10 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 11 Feb 89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES A, BUTLER, LCDR, MC, USN	22e. ADDRESS: NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal	23b. DATE: Feb 12'89	23c. NAME OF CEMETERY OR CREMATORY: Cairo Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: CAIRO, EGYPT	
24. FUNERAL DIRECTOR (OR AUTHORIZED AGENT): [signature]	DeVol Funeral Home Washington, D.C.	25a. DATE REC'D. BY REGISTRAR: FEB 16 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023247 FEB 21 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005350

1. DECEASED NAME (TYPE OR PRINT) FIRST: ADA	MIDDLE: E	LAST: ALLEN	2a. DATE OF DEATH MONTH: 2 DAY: 11 YEAR: 89	2b. HOUR: 1120 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: Mar. DAY: 7 YEAR: 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: own home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince Georges	Adelphi	YES ☒ NO ☐	9617 Laconca Drive 20783

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Samuel J. Robertson	Daisie Carney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A	N/A	415-14-0101	Imogene A. Akers-daughter-	(same as 13e)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac A. Resp Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Dep sis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-7-89 19 to 2-12- 19 89, that (I) (we) last saw the deceased alive on 2-10-89 19, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/12/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SMITH MD	9610 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-15-1989	Rose Hill Cemetery	Berrien Springs Berrien Mich.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines-Rinaldi Funeral Home	11800 N.H. Ave. Sil. Spr. Md.	FEB 16 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024946 MAR 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 05351

1. DECEASED NAME (TYPE OR PRINT) FIRST: ELLEN	MIDDLE: K	LAST: ALLEN	2a. DATE OF DEATH MONTH DAY YEAR: 2-26-1989	2b. HOUR: 6:04 AM	
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: May 2, 1917	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): LATVIA, EUROPE	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Private		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
District	of Columbia	Washington	YES [X] NO [ ]	1429 Columbia Road, N.W. #2

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN	UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	217-30-0300	Billy Allen	1429 Columbia rd., N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis / hypertension	24 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Bowel perforation	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/23 19 89 to 2/26 19 89, that (I) (we) last saw the deceased alive on 2/26 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
S Burns MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Suzanne P. Burns MD	1011 N. Capitol St. Wash. DC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	March 1, 1989	Rock Creek Cemetery	Washington, D.C.

24a. FUNERAL DIRECTOR NAME	ADDRESS	24b. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Stewart Funeral Home	4001 Benning Rd., Washington, D.C.	MAR 02 89	Gilda Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have cards and papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81 (VRA 15.4)

023967 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05352
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21a is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: IRMA	MIDDLE	LAST: Apostolas	2a. DATE OF DEATH MONTH DAY YEAR: 2/18/89	2b. HOUR: 0445 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 21 1893	6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Bakery	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince George	Laurel	YES ☒ NO ☐	401 Cherry Lane 20707

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
F	P	Lare	Josephine		Bashaw

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		301-18-3871	Earl Boswell 14700 4th ST	A-110 Laurel, Md 20707

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septic Shock
DUE TO, OR AS A CONSEQUENCE OF (b): Left lower lobe pneumonia and
DUE TO, OR AS A CONSEQUENCE OF (c): Urinary tract infection
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/17, 1989 to 2/18, 1989, that (I) (we) last saw the deceased alive on 2/17 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
MKarim	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-18-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MOBARAK KARIM	7610 Carroll Ave, Takoma Park, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	Feb 20, 1989	McNabb Crematory	Catonsville Maryland

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donaldson Funeral Home P.A. Laurel, Maryland	FEB 24 1989	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81
(VRA 15, 4)

023372 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053533
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
HERBERT	Lee	ARNOLD	JANUARY 30, 1989	3:40a M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	Caucasian	January 10, 1904	85 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	United States		MONTGOMERY County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
OLNEY	MONTGOMERY GENERAL HOSPITAL	Electrician	Naval Ordinance Lab

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES ☐ NO ☒	14214 Travilah Road/20850

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	Benjamin	Arnold	Emma		Jefferies

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		220-28-5338	Rosie B. Arnold	same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	widely metastatic lung cancer	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).
Sepsis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/5/89, 19____, to 1/30/89, 19____, that (I) (we) last saw the deceased alive on 1/29/89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Arthur F. Woodwood	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ARTHUR F. WOODWOOD, JR. M.D.	#326 18111 Prince Philip Dr. - MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 1, 1989	Parklawn Memorial Park	Rockville Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850	JAN 31 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

025357 MAR 16 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05354 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: DOROTHY	MIDDLE: CRAGG	LAST: ASTON	2a. DATE OF DEATH: FEBRUARY 20, 1989	2b. HOUR: 10:45 P M
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH: DECEMBER 16, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY		MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEDLANTIC AT LAYHILL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 3709 DULWICK DRIVE	20906
14. FATHER'S NAME: HARRY C. CRAGG			15. MOTHER'S MAIDEN NAME: HATTIE DALTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-38-2159	17. INFORMANT: SISTER MARGARET E. CRAGG	ADDRESS: 948 CEDARWOOD AVENUE WEST CHESTER, PA. 19380	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Vascular accident — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/87, 1986, to 2/21, 1989, that (I) (we) last saw the deceased alive on 2/20, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. I. Benack	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/21/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): R. I. BENACK MD	22e. ADDRESS: 4115 Colie Drive, Wheaton, MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 23, 1989	23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN	23d. LOCATION CITY OR TOWN / COUNTY / STATE: SILVER SPRING MONTGOMERY MD.
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901	25a. DATE REC'D. BY REGISTRAR: FEB 22 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

024451 MAR -2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05355
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST Carrie	MIDDLE I.	LAST Baker	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
	Carrie I Baker			2 22 89	4:10 AM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Female	Caucasian	Oct. 10, 1908	80 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia	U.S.A.		Montgomery Co., MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	Shady Grove Adventist Hospital	Homemaker	Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Frederick	Monrovia	YES ☒ NO ☐	28005 Barnes Road 21770

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Roy	E.	Bailey	Leafie	Ann	Lewis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		234 72 2953	Jim Boles (son-in-law)	Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACUTE HEART FAILURE	1 HOUR.
DUE TO, OR AS A CONSEQUENCE OF (b)	ADULT RESPIRATORY DISTRESS SYNDROME	3 DAYS.
DUE TO, OR AS A CONSEQUENCE OF (c)	ISCHEMIC BOWEL	3 WEEKS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

HEPATIC FAILURE, RENAL FAILURE, PROBABLE STROKE, CHOLELITHIASIS, TBP, DM, MYOCARDIAL INFARCTION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/17/89 2/18/89	ISCHEMIC BOWEL, CHOLELITHIASIS ISCHEMIC BOWEL, CHOLELITHIASIS	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐	407 ~~P.M.~~ 2 22 1989	

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2/6/89, 19 89, to 2/22, 19 89, that ~~I~~ (we) last saw the deceased alive on 2/22 19 89, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Kenneth J. Weiss	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
KENNETH J. WEISS MD	9890 MAIN STREET DAMASCUS MD, 20872

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	25 Feb 89	Floral Hills Memorial	Gardens, Quiet Dell, WV

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Capitol Funeral Service, Falls Church, VA	FEB 27 1989	

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

023381 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053556
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
Irma	B.	Bailey	Jan. 31, 1989	10:30 AM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	
Female	White	July 15, 1896	92 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH			
Illinois	U.S.A.		Montgomery MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	Fernwood House	Homemaker	Own Home			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Montgomery	Bethesda	YES ☒ NO ☐	6530 Democracy Blvd./20817

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Otto		Benzing	Lucy		Probst

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	---	577-84-0442	6004 Kingsford Rd. William Bailey, Bethesda, MD 20817

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimers

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from > 19 86 to 1/31 19 89 that (I) (we) last saw the deceased alive on 1/30 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
George Graves MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb. 1, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
George Graves, M.D.	916-19th St., NW, Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	2/2/89	Mt. Comfort Crematory	Alexandria, VA

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016	FEB 02 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

022173 FEB-9 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05357
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Lenous — MIDDLE: J. — LAST: Barnes

2a. DATE OF DEATH — MONTH DAY YEAR: 2-6-89

2b. HOUR: 4:11 P M

3. SEX: M

4. RACE: Negro

5. DATE OF BIRTH — MONTH DAY YEAR: 2 28 18

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Postal Clerk

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Post office

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Mont Co.

13c. CITY OR TOWN: Adelphi

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 7613 Fountainbleu Drive #215

14. FATHER'S NAME — FIRST: Arthur — MIDDLE — LAST: Turner

15. MOTHER'S MAIDEN NAME — FIRST: Beatrice — MIDDLE — LAST: Barnes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 137-14-3444

17. INFORMANT — ADDRESS: Judith Trotter 7613 Fountainbleu Drive #2115

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): acute cardiorespiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic cardiovascular disease — 5 yrs

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic renal disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/15 19 89, to 2/6 19 89, that (I) (we) last saw the deceased alive on 2/6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: Myron L. Lenkin — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MYRON L. LENKIN

22e. ADDRESS: 2309 SHORE FIELD RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02-10-89

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

23d. LOCATION — CITY OR TOWN: Mays Landing — COUNTY — STATE: N. J.

24. FUNERAL DIRECTOR — NAME — ADDRESS: Robert G Mason 1661 Good Hope Road, SE

25a. DATE REC'D. BY REGISTRAR: FEB 08 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If hospital is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024527 MAR

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005358

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Joyce	Carol	Barranco	2	17	1989	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Female	White	8-9-41	47 YRS.			2 17 1989	7:16 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	U.S.A.		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	Administrator	U.S. Navy

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
Maryland	Montgomery	Kensington		3016 Jennings Road 20895

14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Everett	Ellison	Mildred	Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		235 64 0390	Frank A. Barranco 3016 Jennings Road Kensington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE OF MEDICAL EXAMINER Mario F. Golle, Jr. M.D. TITLE (SPECIFY) Assistant DATE SIGNED 2/18/89

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr, M.D. ADDRESS 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2-23-89	Graceland Mem. Park	Ruth, Kanawha, West Virginia	

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Arlington Funeral Home	3901 N. Fairfax Drive Arlington, Virginia	FEB 24 1989	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025362 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005359

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Ruth; MIDDLE: E; LAST: Beier			2a. DATE OF DEATH — MONTH: 2; DAY: 17; YEAR: 89	2b. HOUR: 950 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH — MONTH: 9; DAY: 12; YEAR: 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wisconsin	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fernwood House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	Montg.	Potomac	YES ☒ NO ☐	11108 Hurdle Hill Dr./20845

14. FATHER'S NAME — FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST
Victor / - / Hendrickson	Ingabord / - / Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	-------	524-72-5370	Ruth B. Hudiburgh	Same as # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 9-1 19 88 to 2-17 19 89 that (I) (~~we~~) last saw the deceased alive on 2-12 19 89 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John Taulder	MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-18-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Taulder	8218 Wisconsin Ave. Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Cremation	2/20/89	Chambers Crematory	Riverdale / P.G. / MD.

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W.W. Chambers Co. Inc. 9241 Columbia Blvd. Silver Spring, MD.	FEB 22 '89	Julia Davidson-Randall

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

023471 FEB 22 89

89 053600 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: KATHARYN LOUISE BENJAMIN

2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 16, 1989

2b. HOUR: 7:45P.M

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH MONTH DAY YEAR: NOVEMBER 18, 1918

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NIH, THE CLINICAL CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant

12b. KIND OF BUSINESS OR INDUSTRY: Banking Industry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: NEW YORK

13b. COUNTY: Erie

13c. CITY OR TOWN: BUFFALO

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 23 HIGH ST. #6-A 14203

14. FATHER'S NAME FIRST MIDDLE LAST: Henry Willis

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Mary Marr

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 071-01-4950

17. INFORMANT: LUCILLE W. Rothfus (SISTER)

ADDRESS: 75 Sudbury Lane Amherst, NY 14221

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Esophageal Cancer — 10 Months

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that ☒ (this hospital) attended the deceased from January 17 19 89, to February 16 19 89, that ☒ (we) last saw the deceased alive on February 16 19 89, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (We) (did) (did not) view the body after death.

22b. SIGNATURE: Kevin Conlon MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 2-16-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Kevin Conlon

22e. ADDRESS: NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Feb. 18, 1989

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION CITY OR TOWN COUNTY STATE: Alexandria, Virginia

24. FUNERAL DIRECTOR NAME: Ives-Pearson Funeral Home Arlington, Virginia

25a. DATE REC'D. BY REGISTRAR: FEB 21 1989

25b. REGISTRAR'S SIGNATURE: Gina Barker

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15-4)

025084 MAR 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05361
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Naomi	Middle: Florence	Last: Bennett	2a. DATE OF DEATH Month: 2 Day: 21 Year: 89	2b. HOUR 18:45 M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH Month: August Day: 29 Year: 1916	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Receptionist	12b. KIND OF BUSINESS OR INDUSTRY: Wholesale Grocery		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Faithersburg	YES ☐ NO ☒	11501 Piney Lodge Road 20878

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
Thomas / Hough	Margaret / Pierce	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 212-05-1632	17. INFORMANT (Son) ADDRESS: 11501 Piney Lodge Road John M. Bennett Gaithersburg, Md. 20878

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Ischemic Cardio myopatey	
DUE TO, OR AS A CONSEQUENCE OF (c)	Severe Coronary artery disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/29, 19 89, to 2/8, 19 89, that (I) (we) last saw the deceased alive on 2/21, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
S. Abulfaraj	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
S. Abulfaraj	1902 R St. NW Washington, DC 20009

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	02/22/89	Metropolitan Crematory	Alexandria / Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis GAsch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781	FEB 23 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

(10)

BP____

DHMH - 1650M 1/81 (VRA 15, 4)

025355 MAR 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05362 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or there is any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Willard	MIDDLE: K.	LAST: Bennett	2a. DATE OF DEATH MONTH DAY YEAR: 2-19-89	2b. HOUR: 10:05 PM
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 9, 1917	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CANADA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TAXI DRIVER	12b. KIND OF BUSINESS OR INDUSTRY: YELLOW CAB CO.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: 9205 LONG BRANCH PARKWAY 20901
14. FATHER'S NAME FIRST: EVERETT	MIDDLE: R.	LAST: BENNETT	15. MOTHER'S MAIDEN NAME FIRST: KATHLEEN	MIDDLE: MARGESON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 213-12-1090	17. INFORMANT: ALICE C. BENNETT	ADDRESS: WIFE SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory ARREST	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Non-Hodgkins Lymphoma	2 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12 19 86 to 2-19 19 89, that (I) (we) last saw the deceased alive on 2-13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Frederick G Barr M.D.	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): FREDERICK G. BARR, M.D.	22e. ADDRESS: 2101 MEDICAL PARK DR. SILVER SPRING, MD. 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 23, 1989	23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEMETERY	23d. LOCATION CITY OR TOWN: BRENTWOOD COUNTY: PR. GEO. STATE: MARYLAND
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR: FEB 22 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 101

DHMH - 16 50M 4/83
(VRA 15, 4)

022951 FEB 18 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 005363

1. DECEASED NAME (TYPE OR PRINT): FIRST BETTY MIDDLE JEAN LAST BERLINSKY
2a. DATE OF DEATH: MONTH 2 DAY 9 YEAR 89
2b. HOUR 7:15 A.M.
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 8 DAY 12 YEAR 27
6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY. MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Never Worked
12b. KIND OF BUSINESS OR INDUSTRY: -----

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 6121 Montrose Road (20852)

14. FATHER'S NAME: FIRST Max MIDDLE LAST Berlinsky
15. MOTHER'S MAIDEN NAME: FIRST Ida MIDDLE LAST Katzin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): --------
16b. SOCIAL SECURITY NO.: 212-02-5988
17. INFORMANT: Henry Berlinsky; Brother; 4101 Cathedral Ave. N.W., Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Bilateral Pneumonia. — Approximate interval between onset and death: sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure. — 1 week.
DUE TO, OR AS A CONSEQUENCE OF (c) Down's Syndrome. — since birth.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-5 19 88 to 2-9 19 89, that (I) (we) last saw the deceased alive on 2-9 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Loreto S. Albiol, MD
DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2-9-89.
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LORETO S. ALBIOL, MD
22e. ADDRESS: 6121 MONTROSE Rd.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/10/89
23c. NAME OF CEMETERY OR CREMATORY: Judean Memorial Garden
23d. LOCATION: CITY OR TOWN Olney; COUNTY Montgomery; STATE Maryland

24. FUNERAL DIRECTOR (NAME, ADDRESS): DANZANSKY-GOLDBERG MEMORIAL CHAPELS; 1170 Rockville Pike; Rockville, Md. 20852
25a. DATE REC'D BY REGISTRAR: FEB 14 1989
25b. REGISTRAR'S SIGNATURE: Lilia Knudsen-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

023456 FEB 22 89

REG. NO. 89 005364

1. DECEASED NAME (TYPE OR PRINT): FIRST Lillian MIDDLE LAST Bers
2a. DATE OF DEATH: MONTH DAY YEAR 2 15 89
2b. HOUR: 12:20 AM
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH DAY YEAR March 26, 1908
6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore, Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pers.Officer(Ret.)
12b. KIND OF BUSINESS OR INDUSTRY: U.S.Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 6105 Montrose Road; 20852

14. FATHER'S NAME: FIRST Abraham MIDDLE LAST Buckner
15. MOTHER'S MAIDEN NAME: FIRST Eva MIDDLE LAST Gochroch
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
16b. IF YES, GIVE WAR OR DATES: --------
16b. SOCIAL SECURITY NO.: 579-22-2848
17. INFORMANT: Maurice Bers; Husband; ADDRESS: #4009; Silver Spring, 14510 Homecrest Road, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: seconds
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease — ~~years~~ minutes
DUE TO, OR AS A CONSEQUENCE OF (c): Sudden Cardiac death — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Alzheimers Disease

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-11- 19 89 to 2-15 19 89, that (I) (we) last saw the deceased alive on 2-15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.
22b. SIGNATURE: David A Fuller MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2-15-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): David A Fuller
22e. ADDRESS: 19511 Doctors Dr. Germantown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/17/89
23c. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship Cemetery; Baltimore, Maryland
23d. LOCATION: CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR: NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS; ADDRESS 1170 Rockville Pike; Rockville, Md. 20852
25a. DATE REC'D. BY REGISTRAR: FEB 21 1989
25b. REGISTRAR'S SIGNATURE: Lina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

025300 MAR 1-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05365
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last: MARGARET SHAW BEUKEMA			2a. DATE OF DEATH Month Day Year: FEBRUARY 13 1989	2b. HOUR: 10:45 A M
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH Month Day Year: AUGUST 3 1893	6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WYOMING	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
DISTRICT OF COLUMBIA		Washington, DC	YES ☒ NO ☐	6200 OREGON AVENUE NW	99999 / 20015

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
HENRY ALDEN SHAW	ALICE STANLEY WHITMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	-	213-38-3391	MICHAEL LEONARD, 2850 ARIZONA TERRACE, NW

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — WASHINGTON, DC

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ENDOCARDITIS

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 10 19 89 to FEBRUARY 13 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James A Butler	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	14 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JAMES A. BUTLER, LCDR, MC, USN	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/14/89	Mt. Comfort Crematory	Alexandria, VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016	FEB 15 '89	Julia Davidson-Randall

BP

DHMH - 16 SOM 1/81 (VRA 15, 4)

025296 MAR 16 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05366
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Joseph	Hart	Bien	February 14, 1989	8:50 pm

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	June 29, 1899	89 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, D.C.	U.S.A.		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Shady Grove Nursing Home	Retired Executive	Railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Florida	Broward	Ft. Lauderdale	YES ☒ NO ☐	2500 E. Los Olas Blvd. #402 33301

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Morris		Bien	Lilla	Virginia	Hart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Personal Representative) ADDRESS
NO	-----	718-10-5366	John W. Warren 20309 Highland Hall Dr. Gaithersburg, Md. 20879

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	7 Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Respiratory Arrest	1 minute
DUE TO, OR AS A CONSEQUENCE OF (c)	Pneumonia	less than 1 day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Metastatic Prostatic Cancer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from December 29, 19 88, to February 14, 19 89, that (I) (we) last saw the deceased alive on February 14, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Wayne L. Meyer	MD	☐ ☒ ☐	2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
WAYNE L. MEYER MD	9715 MEDICAL CENTER DRIVE #214 ROCKVILLE, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/16/89	Mt. Comfort Crematory	Alexandria, Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852	FEB 16 '89	Gina Davidson-Randall

024162 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 3 5 6 7

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Lloyd	V.	Bilbo	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH DAY YEAR	2-5-89		2b. HOUR M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
MALE	WHITE	JUNE 18 1925	63 YRS.			2-5- 19 89	11:35 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital of Silver Spring	TRUCK DRIVER	CARLINGS

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	WHEATON		11925 BLUHILL ROAD 20902 BLACK LABEL

14. FATHER'S NAME FIRST / MIDDLE / LAST			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
LEROY		BILBO	GOLDIE HOWDEYSHELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	1943-1945	578-16-1523	MARY K. BILBO/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Contact gunshot wound of head	
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Carcinoma of larynx

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XXX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
	11:00PM 2-5-89	Self inflicted	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	
	home	11925 Bluehill Road, Wheaton, Montgomery Co. Maryland	

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE OF M.D. MEDICAL EXAMINER: Charles P. Kokes

TITLE (SPECIFY): Acting Deputy Chief

DATE SIGNED: 2-56-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D.

ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
BURIAL	FEB 9, 1989	ARLINGTON NATIONAL CEM	ARLINGTON	VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 09'89	Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AFTER PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT AND PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M

BP 12H

DHMH - 17 (VR A15 ME (5))

025384 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005368
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Geraldine Middle: M Last: Black

2a. DATE OF DEATH Month Day Year: 02-17-89

2b. HOUR: 1.35PM

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH Month Day Year: August 9,1921

6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Chevy Chase

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 3713 Chevy Chase Lake Drive,#4 Zip: 20815

14. FATHER'S NAME First: Charles Middle: Wetzel Last: Aucker

15. MOTHER'S MAIDEN NAME First: Olive Middle: Marie Last: Bell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): -

16b. SOCIAL SECURITY NO.: 178-16-5132

17. INFORMANT ADDRESS: Mr. William O. Suddath, Son-in-law, 28204 Ridgepoint Crt., Palos Ranchos Verdes, California

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory insufficiency — Approximate interval between onset and death: three days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): brain Metastases — six months

DUE TO, OR AS A CONSEQUENCE OF (c): breast cancer — 20 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO XX

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov 1 19 88 to Feb. 17 19 89, that (I) (we) last saw the deceased alive on Feb. 17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Feb. 17, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. Peter Pushkas

22e. ADDRESS: 11510 Old Georgetown Rd. Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: February 21, 1989

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Rockville / Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland

DATE RECD. BY REGISTRAR: FEB 21 89

REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP 10

DHMH-16 50M 1/81 (VRA 15, 4)

025299 MAR 16

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005369

1. DECEASED NAME (TYPE OR PRINT): FIRST RALpH MIDDLE E. LAST BlACK

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 02 DAY 13 YEAR 1989

2b. HOUR 145 AM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH July DAY 11 YEAR 1919

6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.

IF UNDER 1 YR. MONTHS ___ DAYS ___ IF UNDER 24 HRS. HOURS ___ MIN ___

2c. DATE PRONOUNCED DEAD: MONTH 02 DAY 13 YEAR 1989

2d. HOUR 145 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Consultant

12b. KIND OF BUSINESS OR INDUSTRY: A.S.O.L.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 7005 Winslow St./20817

14. FATHER'S NAME: FIRST Ernest MIDDLE - LAST Black

15. MOTHER'S MAIDEN NAME: FIRST UNKNOWN MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): ---------

16b. SOCIAL SECURITY NO.: 122-18-3009

17. INFORMANT ADDRESS: Eva Black 7005 Winslow St. Bethesda, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiogenic Shock

Conditions, if ony, which gave rise to immediate couse (a) stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c): ___

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☑ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☑, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Tamburr M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-14-89 Bethesda Md.

EXAMINER'S NAME (TYPE OR PRINT): John Tamburr ADDRESS: 8218 WISCONSIN AVE

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: 2-15-1989

23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREMATORY

23d. LOCATION CITY OR TOWN: RIVERDALE COUNTY: P.G.C., STATE: Md.

24. FUNERAL DIRECTOR NAME: W. W. CHAMBERS CO. INC. ADDRESS: SILVER SPRING, 20910 Md.

25a. DATE REC'D. BY REGISTRAR: FEB 16 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 3

DHMH - 17 (VR A15 ME (5))

023179 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05370
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Anna	Middle:	Last: Blatt	2a. DATE OF DEATH Month Day Year: 2-10-89		2b. HOUR: 7 P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month Day Year: 8 9 02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES X NO ☐	6121 Montrose Road (20852)

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
Isaac / / Kampel	Sarah / / Schiff	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	----------	225-66-2236	Jeanne Kortlang;Daughter;3614 Orkland Dr.;	Alexandria, Va.22310

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	Seconds
DUE TO, OR AS A CONSEQUENCE OF (b)	MI (Myocardial Infarction)	minutes
DUE TO, OR AS A CONSEQUENCE OF (c)	Atherosclerotic cardiovascular disease	years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 3-27-86 19 89 to 2-10 19 87, that (I) (we) last saw the deceased alive on 2/10 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-11-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Daniel A Jaller 22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/13/89	King David Mem. Garden	Falls Church; Fairfax; Va.

24. FUNERAL DIRECTOR NAME / ADDRESS: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE RECEIVED BY REGISTRAR: FEB 15 1989 25b. REGISTRAR'S SIGNATURE:

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024697 MAR 3 90

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053711
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completely pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: O.	LAST: BLEDSOE	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 24, 1989	2b. HOUR: 8:30 A M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: FEB. 9, 1906	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR MONTHS / DAYS:	IF UNDER 24 HRS. HOURS / MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1 99 ROLLINS AVENUE	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: HOME		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	MONTGOMERY	ROCKVILLE	YES ☒ NO ☐	199 ROLLINS AVENUE 20852

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
CHARLES – COLE	CLEMENTINE – WOLFE	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT	
NO		219-48-2970	JOHN BLEDSOE	18041 BENTLEY ROAD SANDY SPRING, MD. 20860

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	acute cardiac awhythimia	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	atherosclerotic cardiavascular disease	unknown
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): gastric ulcer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital attended the deceased from Aug 8, 19 85, to Feb. 24, 19 89, that (I) (we) last saw the deceased alive on Feb. 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. Peter Pushkas — 22e. ADDRESS: 11510 Old Georgetown Rd. Rockville md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB. 27, 1989	MT. CARMEL	SUNSHINE MONT. MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MURIEL H. BARBER LAYTONSVILLE, MD. 20879	FEB 28 1989	Gina Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

023947 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05372
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 7 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Hyman	MIDDLE	LAST: Blum	2a. DATE OF DEATH MONTH DAY YEAR: Feb. 18, 1989	2b. HOUR: PM	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 22, 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Russia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.			
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11919 Parklawn Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner-Operator	12b. KIND OF BUSINESS OR INDUSTRY: Dry Cleaner			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 11919 Parklawn Drive 20852		
14. FATHER'S NAME FIRST MIDDLE LAST: Shimon Moskowitz	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Sarah Lebowitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 578 09 4715	17. INFORMANT ADDRESS: Son: Samuel Blum 1201 Potomac Valley Rockville, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia	2 days
DUE TO, OR AS A CONSEQUENCE OF (b)	cerebral arteriosclerosis	10 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒ XX	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒ XX

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ XXXXX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/19, 19 88, to ---, 19 89, that (I) (we) last saw the deceased alive on 2/3, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. XXXXX

22b. SIGNATURE: Marvin Wadler, M.D.	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/21/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARVIN WADLER	22e. ADDRESS: 5218 Wisconsin Av. Bethesda Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 21, 1989	23c. NAME OF CEMETERY OR CREMATORY: King David Memorial Gardens	23d. LOCATION CITY OR TOWN / STATE: Falls Church, Va	
24. FUNERAL DIRECTOR NAME / ADDRESS: Ives-Pearson Funeral Homes Falls Church, Va. 22046	25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau		

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 053723

024132 FEB 29 89

DR MAYLE had been notified by rel 2/10

1a. DECEASED NAME (TYPE OR PRINT) — FIRST: WARREN — MIDDLE: F. — LAST: BOND

2a. DATE OF DEATH — MONTH DAY YEAR: February 5, 89

2b. HOUR: 12:00x

3. SEX: Male

4. RACE: Black

5. DATE OF BIRTH — MONTH DAY YEAR: March 1, 1921

6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1641 E. Jefferson St

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Fork Lift Oper.

12b. KIND OF BUSINESS OR INDUSTRY: Holiday Tyle

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montg.

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 1641 E. Jefferson St, 20852

14. FATHER'S NAME — FIRST: Richard — MIDDLE — LAST: Bond

15. MOTHER'S MAIDEN NAME — FIRST: Isabelle — MIDDLE — LAST: Steuart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-14-2788

17. INFORMANT — ADDRESS: Mrs Gloria M. Bond (Wife) — Same As #13 E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): probable Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Severe atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-88 19 88, to 9-28 19 88, that (I) (we) last saw the deceased alive on 9-28 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H Bahar — DEGREE — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2-6-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): HADI BAHAR

22e. ADDRESS: 11500 Rockville Pike

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-11-89

23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial

23d. LOCATION — CITY OR TOWN — COUNTY — STATE: Suitland, Pr Geo. Md

24. FUNERAL DIRECTOR — NAME — ADDRESS: George R. Snowden — 246 N. Washington St, Rockville, Md

25a. DATE REC'D. BY REGISTRAR: FEB 08 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The duplicate carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

023366 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005374

1. DECEASED NAME (TYPE OR PRINT) FIRST: Lucille	MIDDLE: E.	LAST: Bowie	2a. DATE OF DEATH MONTH: 1	DAY: 27	YEAR: 89
2b. HOUR: 0715 AM					

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	CAUCASIAN	SEPT	21	1923	65 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
NEBRASKA	USA		MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
TAKOMA PARK	WASHINGTON ADVENTIST HOSPITAL	HOMEMAKER	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	KENSINGTON	YES ☐ NO ☐	10709 BRUNSWICK AVENUE 20895

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
HARRY		KLAUSCHIE	BESSIE		TRECEK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	505-22-0903	RUSSELL P. BOWIE/HUSBAND/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) glioblastoma multiforme
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/20 19 88 to 1/27 19 89, that (I) (we) last saw the deceased alive on 1/26 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN ☑	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	1/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
KIRKLAND C. BRACE	7600 CARROLL AVE, TAKOMA PARK

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	JAN 30, 1989	PARKLAWN CEMETERY	ROCKVILLE MONTGOMERY MD

24. FUNERAL DIRECTOR NAME AND ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	JAN 30 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

0 2 5 3 6 5 MAR 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR — REG. NO. 89 005375

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	WAYNE L. BOYER	2a. DATE OF DEATH — MONTH DAY YEAR	2-21-89
		2b. HOUR	0500 AM
3. SEX	MALE	4. RACE	WHITE
5. DATE OF BIRTH — MONTH DAY YEAR	AUG. 2, 1904	6. AGE (IN YEARS LAST BIRTHDAY)	84 YRS
IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY CO. MD.
10. CITY OR TOWN OF DEATH	TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	WASHINGTON ADVENTIST HOSP'T.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	INDUSTRIAL ENGINEER - FED. GOV'T	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	MONTGOMERY	SILVER SPRING	YES ☒ NO ☐	9207 2nd AVE. 20910

14. FATHER'S NAME — FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST
SAMUEL REITZEL BOYER	IDA LINDSAY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	-------	218-24-2009	CRAIG N. BOYER	7413 NEWBURG DR. LANHAM, MD. 20706

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	11 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Obstructive Lung Disease	5 Years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10 Feb 89 to 21 Feb 89, that (I) (we) last saw the deceased alive on 20 Feb 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ((I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	21 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Michael Leibowitz MD	11200 Lee Hwy Fairfax, Va 22030

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
CREMATION	2-22-1989	CHAMBERS CREMATORY	RIVERDALE, P.G.C. Md.

24. FUNERAL DIRECTOR — NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO. INC.	SILVER SPRING, MD. 20910	FEB 22 '89	Julia Davidson-Randall

BP 25

DHMH - 16 50M 1/81 (VRA 15, 4)

025298 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005376

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert	MIDDLE: L	LAST: Bradford	2a. DATE OF DEATH MONTH DAY YEAR: 2/14/89		2b. HOUR: 6:35 PM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: June 17, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County		MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS): Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanical Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Self Employed	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES ☐ NO ☒	7514 Radnor Road/20817

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James	Clifton	Bradford	Jessie	May	Cummerlander

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	577-10-3849	Louise H. Bradford same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Intractible Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Carcinoma Prostate cmets Genito Urin. Chronic Anemia.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2/13 19 89 to 2/14 19 89, that (I) (~~saw~~) last saw the deceased alive on 2/13 19 89 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~have~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: J. Blaine Fitzgerald M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 3/14/89.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Blaine Fitzgerald, M.D.

22e. ADDRESS: 8218 Wisconsin Avenue, Bethesda, MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 18, 1989	Fort Lincoln Cemetery	Brentwood / Maryland

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814	FEB 16 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

024452 MAR 2-88 #13abcde FilmG651 5/10/89 kam

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05377 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Florence	MIDDLE	LAST: Braunstein	2a. DATE OF DEATH MONTH: 02 DAY: 24 YEAR: 89	2b. HOUR: 1:25AM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Mar. 4, 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Russia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
New Jersey		East Orange	YES ☐ NO ☐	220 Prospect St., Apt. 8C-J 07017

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel		Haft	Flora		Sanbur

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	136-03-4787	Sonya Mandel	6028 Sandy Lane Tobyanna, Pa. 08816

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis — days
DUE TO, OR AS A CONSEQUENCE OF (c) Hepatic Failure and Coma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/23 19 88 to 2/23 19 89, that (I) (we) last saw the deceased alive on 2/23 19 89, and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above; ~~(I)~~ (we) ~~did~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Daniel Anderson	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DANIEL L. ANDERSON	29101 Olney-Sandy Spring Rd Olney MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/26/89	Mt. Lebanon Cemetery	Iselin, New Jersey

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ives-Pearson Funeral Home	2847 Wilson Blvd., Arlington, Va. 22201	FEB 27 1989	Gloria Davidson-Handsell

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024704 MAR 6 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005378

1. DECEASED NAME (TYPE OR PRINT): FIRST Bernadette MIDDLE S. LAST Brock

2a. DATE OF DEATH: MONTH 02 DAY 26 YEAR 89

2b. HOUR: 9:26 P.M.

3. SEX: ~~Male~~ Female

4. RACE: White

5. DATE OF BIRTH: MONTH 5 DAY 26 YEAR 20

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON DC

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: TAKOMA PARK

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RECEPTIONIST

12b. KIND OF BUSINESS OR INDUSTRY: FED GOVT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: PR. GEO.

13c. CITY OR TOWN: HYATTSVILLE

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: 3450 TOLEDO TERRACE 20783

14. FATHER'S NAME: FIRST MIDDLE LAST STEFONICK

15. MOTHER'S MAIDEN NAME: FIRST MIDDLE LAST NOT AVAILABLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-12-6216

17. INFORMANT ADDRESS: WM. L. RURPIUS-BROCK, CROOKSTEN, MINN.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ~ 3 WEEKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): SEVERE C.O.P.D.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

CONGESTIVE HEART FAILURE HYPERTENSION, OBESITY, DIABETES M.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 1/29 19 89 to 2/26 19 89, that (I) (~~we~~) last saw the deceased alive on 2/26 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: Joseph B. Mizgerd, M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSEPH B MIZGERD, M.D.

22e. ADDRESS: 7600 CARROLL AVE TAKOMA PARK, MD 20912

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: March 3. 1989

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Arlington Virginia

24. FUNERAL DIRECTOR NAME ADDRESS: Takoma Funeral Home J.C. Nelson, 257 Carroll Ave N.W. DC

25a. DATE REC'D. BY REGISTRAR: MAR 2 - 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

018750 JAN 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

B 9 053799

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Leslie	Monroe	Briggs	2a. DATE OF DEATH — KNOWN XX / ESTIMATED ☐ — MONTH / DAY / YEAR	1-5 19 89
2b. HOUR	M			2c. DATE PRONOUNCED DEAD — MONTH / DAY / YEAR	1-5 19 89
2d. HOUR	7:15 p. M				
3. SEX	Male				
4. RACE	White				
5. DATE OF BIRTH — MONTH / DAY / YEAR	Sept. 21, 1913				
6. AGE (IN YEARS LAST BIRTHDAY)	75 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland				
7b. CITIZEN OF WHAT COUNTRY?	USA				
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X					
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery County, MD.				
10. CITY OR TOWN OF DEATH	Rockville				
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Shady Grove Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Farmer				
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland				
13b. COUNTY	Frederick				
13c. CITY OR TOWN	Ijamsville				
13d. INSIDE CITY LIMITS? YES ☐ NO ☒					
13e. STREET ADDRESS	9914 Fire Tower Rd. 21754				
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Zechariah	Thomas	Briggs		
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Elenora		Power		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	No				
IF YES, GIVE WAR OR DATES					
16b. SOCIAL SECURITY NO.	217-09-4581				
17. INFORMANT — ADDRESS	Mary Virginia Briggs Maher, Oak Hill, W.Va.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES X NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from / Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Golle Jr. M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 1-7-89

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Jan. 10, 1989	Mount Olivet	Frederick, Frederick, Md.
24. FUNERAL DIRECTOR NAME / ADDRESS	Olin L. Molesworth, P.A., Damascus, Md.	25a. DATE REC'D. BY REGISTRAR	JAN 10 1989
25b. REGISTRAR'S SIGNATURE			

BP

DHMH - 17
(VR A15 ME (5))

0 2 3 8 5 1 FEB 26 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005380 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Bernard	MIDDLE: Wellington	LAST: Brooke	2a. DATE OF DEATH MONTH: 02 DAY: 10 YEAR: 89	2b. HOUR: 11 12 P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 21, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Self-employed	12b. KIND OF BUSINESS OR INDUSTRY: Carpenter		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN: Washington, DC	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 715-Kentucky Avenue, S.E. 20003	
14. FATHER'S NAME FIRST: Eugene	MIDDLE: E.	LAST: Brooke	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: Agnes	LAST: Lynch
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579-05-1652A	17. INFORMANT: Matthew A. Kane (Attorney)	ADDRESS: 4720-Montgomery La., Bethesda, MD 20814	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Broncho Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus, Organic Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-21 19 89, to 2-10 19 89, that (I) (~~me~~) last saw the deceased alive on 2-10 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~me~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-11-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Tauber	22e. ADDRESS: 8218 Wisconsin Ave Bethesda md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: Feb. 15, 1989	23c. NAME OF CEMETERY OR CREMATORY: Lee's Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Washington, District of Columbia	
24. FUNERAL DIRECTOR NAME / ADDRESS: J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002		25a. DATE REC'D. BY REGISTRAR: FEB 21 1989	25b. REGISTRAR'S SIGNATURE: Erma Davidson-Randall	

BP

DHMH - 1650M1/81 (VRA 15, 4)

024070 FEB 20 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05381
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DORIS	MIDDLE: D.	LAST: BROWER	2a. DATE OF DEATH MONTH DAY YEAR: 2-10-89	2b. HOUR: 3:55 P M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: May 15, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Canada	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Legal Asst.	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince George's	Greenbelt	YES ☒ NO ☐	9322 Edmonston Road 20770

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Solomon Shawn	Ida Braunstein

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		132-16-2072	Margaret E. Brower-Balazik 501 Paradise Court Gaithersburg, Md. 20877

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF RIGHT LUNG
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 YRS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 25 19 89, to FEBRUARY 10 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 10 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~attended~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James L. Brownlow	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JAMES A. BROWN MD	14808 PHYSICIANS LANE #212 ROCKVILLE, MD. 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb. 14 1989	Metropolitan Crem.	Alexandria Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, Maryland 20877	FEB 16'89	Lydia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

024514 MAR 1-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053823 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: OLGA	MIDDLE: M.	LAST: BROWN	2a. DATE OF DEATH MONTH DAY YEAR: 2-21-89	2b. HOUR: 935 P.M.	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: DEC. 21, 1893	6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GERMANY	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: GAITHERSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson HealthCare Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: HOME		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	MONT.	GAITHERSBURG	YES ☒ NO ☐	401 RUSSELL AVE. 20877

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	ADDRESS
MATHIAS - FODERBERG	MAGDALENA P. LUBKERT	7 TREADWAY ROAD BROOKEVILLE, MD. 20833

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT
NO		213-56-1940	BARBARA B. DEBOLE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio-Pulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): A.S.H.D. & C.H.F — Months

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 70, to 2-21-89, 19 ____, that (I) (~~was~~) last saw the deceased alive on 2-21-89, 19 ____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~was~~) (and) (did not) view the body after death.

22b. SIGNATURE / DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Jack Schumacher M.D.	☐ ☑ ☐	2-22-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. JACK SCHUMACHER	GAITHERSBURG, MD. 20877

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	FEB. 23, 1989	BALT. WASH. CREMATORY	LAUREL P. GEORGE MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MURIEL H. BARBER	LAYTONSVILLE, MD. 20879	FEB 27 1989	Gina Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

022439 FEB 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR Guy E. Broyles SR.

REG. NO. 005383

1. DECEASED NAME (TYPE OR PRINT): FIRST Guy MIDDLE E. LAST Broyles SR.

2a. DATE KNOWN OF DEATH ESTIMATED ☐: MONTH Feb. DAY 1 YEAR 1989 — 2b. HOUR 2:00 AM/PM

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH June DAY 28 YEAR 33 — 6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb. DAY 1 YEAR 1989 — 2d. HOUR 2:30 AM/PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Olney — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Mont. General Hosp. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Landscaper — 12b. KIND OF BUSINESS OR INDUSTRY: Landscaping

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Brinklow — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 19200 New Hampshire Ave., 20862

14. FATHER'S NAME: FIRST Clifford MIDDLE C. LAST Broyles

15. MOTHER'S MAIDEN NAME: FIRST Mabel MIDDLE - LAST Reeves

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): Korean

16b. SOCIAL SECURITY NO.: 217-32-0048

17. INFORMANT: Guy E. Broyles, Jr. — ADDRESS: 3820 Purdum Dr. Mt. Airy, Md. 21771

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Disf. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Dep. — MEDICAL EXAMINER — DATE SIGNED: Feb. 1, 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers — ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Feb. 4, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery — 23d. LOCATION CITY OR TOWN: Burtonsville — COUNTY: Mont. — STATE: Md.

24. FUNERAL DIRECTOR NAME: Muriel H. Barber — ADDRESS: Funeral Home, Laytonsville, Md. 20879

25a. DATE REC'D BY REGISTRAR: FEB 6 1989 — 25b. REGISTRAR'S SIGNATURE: Jicha Davidson-Kendell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

07/84 25M — BP — DHMH - 17 (VR A15 ME (5))

023363 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05384
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: James	MIDDLE: L.	LAST: Brown	2a. DATE OF DEATH: January 31, 1989	2b. HOUR: 1:35 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Mar. 5, 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., DC	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Potomac	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Manor Care-Potomac	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner	12b. KIND OF BUSINESS OR INDUSTRY: Furniture Co.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Mont.	Potomac	YES [X] NO [ ]	10023 Kendale Rd. 20854

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Andrew		Brown	Louise		Specht

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		577-48-1876	Richard H. Carter	Same as item # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Carcinoma ~~Right~~ Colon	6 1/2 mos.
DUE TO, OR AS A CONSEQUENCE OF (b)	Adeno Carcinoma Right Colon	6 1/2 mos.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Adeno Carcinoma Prostate Gland

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 86 to 1/31 19 89, that (I) (he) last saw the deceased alive on 1/28 19 89 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
J. Blaine Fitzgerald MD		ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	1/31/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Blaine Fitzgerald, MD		22e. ADDRESS: 8218 WI Ave. Beth., MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
Burial	2/3/89	Parklawn Cem.	Rockville, MD

24. FUNERAL DIRECTOR: NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016	FEB 02 '89	Lia Davidson-Randell

BP 20

DHMH - 16 50M 1/81 (VRA 15, 4)

023362 FEB 2 '89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

89 REG. NO. 005385

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MILDRED — MIDDLE: O. — LAST: BROWN

2a. DATE OF DEATH — MONTH DAY YEAR: 1-26-89

2b. HOUR: 5:00 A M

3. SEX: F

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH DAY YEAR: 1-30-1904

6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS

IF UNDER 1 YEAR — MONTHS / DAYS

IF UNDER 24 HRS — HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: TAKOMA Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: PG

13c. CITY OR TOWN: Beltsville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 4102 Kenny St 20705

14. FATHER'S NAME — FIRST: John — MIDDLE: Redmiles — LAST:

15. MOTHER'S MAIDEN NAME — FIRST: Caroline — MIDDLE: Shorts — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 219307128

17. INFORMANT — ADDRESS: Earl Brown - Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO-PULMONARY ARREST.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF (c): ACUTE MYOCARDIAL INFARCTION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE:

22a. I certify that (I) (this hospital) attended the deceased from 1-19- 19 89, to 1-26- 19 89, that (I) (we) last saw the deceased alive on 1-25- 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) ~~did~~ (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1-26-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. H. CHAUDHRY MD

22e. ADDRESS: 14201 Laurel Parke DRIVE #100, Laurel Md 20707.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 28 1989

23c. NAME OF CEMETERY OR CREMATORY: Savage Cem

23d. LOCATION — CITY OR TOWN: Savage — COUNTY: — STATE: Md

24. FUNERAL DIRECTOR — NAME: Donaldson Funeral Home — ADDRESS: Laurel Md.

25a. DATE REC'D. BY REGISTRAR: FEB 01 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024161 FEB 2 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05386
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 8

DHMH - 16 50M 4/83
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Meride MIDDLE: V. LAST: Canepa Bruzzo			2a. DATE OF DEATH MONTH DAY YEAR: FEB. 5, 1989	2b. HOUR: 5:45 P.M.
MERIDE V. BRUZZO				
3. SEX: Female	4. RACE: Cauc	5. DATE OF BIRTH MONTH DAY YEAR: 2 16 16	6. AGE (IN YEARS LAST BIRTHDAY) YRS.: 72	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Italy	7b. CITIZEN OF WHAT COUNTRY?: Italy	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Montgomery	Silver Spring	YES ☐ NO ☐	13921 Huxley Cove Ct./20906

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Canepa / Giouanni / Batista	Chidini / -- / Diomira

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	---	579-76-5499	Aurelio G. Bruzzo, Same address as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 HR.
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY EMBOLUS — 10 HR.
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1. OBESITY 2. HYPERTENSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
NOV. 1988	ABDOMINAL HYSTERECTOMY	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from FEB. 5 19 89 to FEB. 5 19 89, that (I) (~~was~~) last saw the deceased alive on FEB 5 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~have~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Harold S. Tidler M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	FEB. 5, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Harold S. Tidler	9801 Georgia Ave, Silver Spring, MD 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial-Removal	2-13-89	Castagna Cem	Castagna, Italy

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc.	5130 Wisconsin Ave, NW, Washington, D.C. 20016	FEB 08 '89	Julia Davidson-Randall

124145 FEB 29 19 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053887 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other than natural event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Edward	MIDDLE: Giles	LAST: Bucklin, Jr.	2a. DATE OF DEATH MONTH DAY YEAR: February 1, 1989	2b. HOUR: 7:10p M	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: November 26, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Manor Care Nursing Home-Wheaton	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Model Maker	12b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy Department		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 11909 Ashley Drive, Rockville, Maryland 20852	
14. FATHER'S NAME FIRST MIDDLE LAST: Edward Giles Bucklin, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Edna Tippett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-38-0942	17. INFORMANT: Robert Giles Bucklin,	ADDRESS: 14808 Dufief Drive, Gaithersburg, Maryland 20878	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): TRANSITIONAL CARCINOMA OF BLADDER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC OBSTUCTIVE PULMONARY DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~XXXXXX~~) attended the deceased from May 5, 19 88, to February 1, 19 89, that (I) (~~XX~~) last saw the deceased alive on December 28, 19 88, and that in (my) (~~XX~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~XX~~) (~~XX~~) (did not) view the body after death.

22b. SIGNATURE: Kathryn S. Kirwin DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: February 02, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Kathryn S. Kirwin, M.D. — 22e. ADDRESS: 10400 Connecticut Avenue Kensington, Md. 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 4, 1989	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN: Brentwood, COUNTY: PrinceGeorges, STATE: Maryland
24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home, Inc. ADDRESS: 300 West Montgomery Avenue, Rockville, Maryland	25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

025292 MAR 14 - 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053883
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Emily	M.	Buhl	February 14, 1989	3:40 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	Caucasian	Oct. 18, 1894	94 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
New Jersey	United States		Montgomery County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Rockville Nursing Home	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Chevy Chase	YES ☐ NO ☒	3215 Brooklawn Terrace/20815

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William		Haelig	Julia		Kallenberg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		155 36 9926	John E. Buhl, Jr. son see #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebralvascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebral vascular Disease — years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 25, 1982, to Feb 14, 1989, that (I) (we) last saw the deceased alive on Jan 16, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (XXX) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Barry Hecht	M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb. 14, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Barry Hecht, M.D.	3941 Ferrara Drive, Wheaton, Maryland 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 18, 1989	St. Joseph's Cemetery	Bound Brook, New Jersey

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home-Bethesda-Chevy Chase, Inc. 7557 Wisconsin Av., Bethesda, Md. 20814	FEB 16 '89	Lucia Davidson-Randall

BP 10

DHMH - 16 60M 7/84
(VRA 15, 4)

024089 FEB 13 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005389

1. DECEASED NAME (TYPE OR PRINT)	FIRST Dennis	MIDDLE Paul	LAST Bunner	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐	MONTH 2	DAY 8	YEAR 89	2b. HOUR	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	MONTH 2	DAY 8	YEAR 89	2d. HOUR	M
Male	White	Dec. 12, 1950	38 YRS.							7:10	A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	U.S.A.		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	Registered Nurse	Suburban Hospital

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES XX NO ☐	12102 Edgemont Street 20902

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Harlan	Bunner	Ada	Hays
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	Viet Nam	236-82-8938	Dennis nmn Keefer (friend) same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Complications of Acute Immunodeficiency Syndrome	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b)	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ TITLE (SPECIFY) Assistant M.D. _____ MEDICAL EXAMINER DATE SIGNED 2-9-89

VC EXAMINER'S NAME (TYPE OR PRINT) James Kaplan, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/14/89	Hartley Cemetery	Brohard, West Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852	FEB 13 '89	Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M

BP 84 grant 2

DHMH - 17
(VR A15 ME (5))

024971 MAR - 1 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05390
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then type or use carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 141

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROGER	MIDDLE: HAMLIN	LAST: BURKE	2a. DATE OF DEATH MONTH: JANUARY	DAY: 18,	YEAR: 1989	2b. HOUR: 8:30a M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: OCTOBER DAY: 4, YEAR: 1918	6. AGE (IN YEARS LAST BIRTHDAY): ~~71~~ 70 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN): MASSACHUSETTES	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH: GAITHERSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11527 SULLNICK WAY	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): U.S. ARMY	12b. KIND OF BUSINESS OR INDUSTRY: MILITARY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: GAITHERSBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 11527 SULLNICK WAY, 02745	
14. FATHER'S NAME FIRST: MATHIEW	MIDDLE: JAMES	LAST: BURKE	15. MOTHER'S MAIDEN NAME FIRST: SARAH	MIDDLE: CUSHING	LAST: PIERCE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 014-16-1963	17. INFORMANT: DAVID R. BURKE (SON)	ADDRESS: SAME AS 13		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sudden out of hospital death	2 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Haemophilus influenza pneumonia	3 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	chronic obstructive pulmonary disease	Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 23 DEC, 19 88, to 14 Jan, 19 89, that (I) (we) last saw the deceased alive on 14 JAN 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Karen Murry MD	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 18 Jan 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): KAREN MURRY, M.D.	22e. ADDRESS: 6825 16th STREET N.W. WASHINGTON D.C.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: JAN. 21, 1989	23c. NAME OF CEMETERY OR CREMATORY: ACUSHNET CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: ACUSHNET, BRISTOL, MA
24. FUNERAL DIRECTOR NAME: W.W. CHAMBERS CO	ADDRESS: 9241 COLUMBIA BLVD SILVER SPRING, MD	25a. DATE REC'D BY REGISTRAR: JAN 23 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

024092 FEB 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 REG. NO. 05391

1. DECEASED NAME (TYPE OR PRINT): FIRST James MIDDLE FREDERICK LAST Bunting

2a. DATE OF DEATH: MONTH DAY YEAR 2-7-89

2b. HOUR 4:35 A M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH DAY YEAR AUG. 17, 1906

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD.

10. CITY OR TOWN OF DEATH: Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PROFESSIONAL DIRECTOR- Y.M.C.A.

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: GAITHERSBURG

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 301 RUSSELL AVE. 20877

14. FATHER'S NAME: FIRST JAMES MIDDLE LAST BUNTING

15. MOTHER'S MAIDEN NAME: FIRST LUCRETIA MIDDLE EMELINE LAST CHENEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): --------

16b. SOCIAL SECURITY NO.: 143-26-3534

17. INFORMANT: EMILY BUNTING ADDRESS: 407 RUSSELL AVE.#5G,GAITHERS-BURG Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): dementia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-7 19 88 to 2-7 19 89 that (I) (we) last saw the deceased alive on 2-7 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John Melnick DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Melnick

22e. ADDRESS: 911 Russell Ave. Gaithersburg Md 20879

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2-7-1989

23c. NAME OF CEMETERY OR CREMATORY: Chambers Crematory

23d. LOCATION: CITY OR TOWN Riverdale COUNTY P.G. Co. STATE MD

24. FUNERAL DIRECTOR NAME: W.W.Chambers Co. Inc. ADDRESS: 9241 Columbia Blvd. Silver Spring,MD

25a. DATE REC'D. BY REGISTRAR: FEB 08'89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 2

DHMH - 16 60M 7/84 (VRA 15, 4)

024101 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05392
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Gladys — MIDDLE: — LAST: Butler

2a. DATE OF DEATH — MONTH DAY YEAR: 2/2/89 — 2b. HOUR: 1415 M

3. SEX: FEMALE

4. RACE: BLACK

5. DATE OF BIRTH — MONTH DAY YEAR: June 26, 1912

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: Federal Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: District of Columbia — 13b. COUNTY — 13c. CITY OR TOWN: Washington — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 906 12th Street, N.E.

14. FATHER'S NAME — FIRST: Hadden — MIDDLE: — LAST: Branson

15. MOTHER'S MAIDEN NAME — FIRST: Celia — MIDDLE: — LAST: Briscoe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — IF YES, GIVE WAR OR DATES: N/A

16b. SOCIAL SECURITY NO.: 579-20-9320

17. INFORMANT — ADDRESS: 1805 Brierfield Road Lawrence Green Oxon Hill, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bilateral Bronchopneumonia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-1, 19 89, to 2-2, 19 89, that (I) (we) last saw the deceased alive on 2-2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John Tauber — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-2-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Tauber

22e. ADDRESS: 8218 Wisconsin Ave (see the second)

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: February 7, 1989

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION — CITY OR TOWN: Washington — COUNTY: D.C. — STATE:

24. FUNERAL DIRECTOR — NAME: Joseph T. Stewart, III — ADDRESS: 4001 Benning Rd., Washington, D.C. — Stewart Funeral Home

25a. DATE REC'D. BY REGISTRAR: FEB 15 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 2

DHMH - J650M 1/81 (VRA 15, 4)

023330 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05393
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jesse	MIDDLE: F	LAST: Campbell	2a. DATE OF DEATH MONTH DAY YEAR: 02 01 89	2b. HOUR: 905 PM	
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: AUG 18 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PAINTER & FURNITURE REFINISHER	12b. KIND OF BUSINESS OR INDUSTRY: HILTON HOTEL		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [X]	10820 GEORGIA AVE 20902

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN	HENRY	CAMPBELL	SARAH	MARGARET	CHENOWITH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		226-05-7810	ELTON CAMPBELL/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	< 24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Septicemia	< 24 hrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Bilateral interstitial lung infiltrates	< 24 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): (4) metastatic renal cell cancer (5) prostatic cancer.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M./P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 03-29 19 88 to 02-01 19 89 that (I) (we) last saw the deceased alive on 02-01 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Albert K Lee MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	02-01-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ALBERT K. LEE, MD	8218 Wisconsin Ave, Ste 105 Bethesda MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 4, 1989	THORNROSE CEMETERY	STAUNTON AUGUSTA VIRGINIA

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 06 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

024135 FEB 2 9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053941 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, those removal-authorization papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Eugene; MIDDLE: A.; LAST: Caporaletti			2a. DATE OF DEATH MONTH DAY YEAR: Jan. 27 1989
2b. HOUR: 2:35 P.M.			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 15 1930	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS.
IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS. HOURS MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE): Pres. United Electrical sales Associates	12b. KIND OF BUSINESS OR INDUSTRY: Self Employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Potomac	YES [X] NO [ ]	9404 Falls Bridge Lane 20854

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Attilio / / Caporaletti	Stella / / DiPierro

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes		579-42-2382	Louise Caporaletti -wife- (same as 13e)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SHOCK — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Hemorrhagic Gastro-enteritis — 1 week

DUE TO, OR AS A CONSEQUENCE OF (c): Laennec's Cirrhosis — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan. 27, 19 89, to Jan 27, 19 89, that (I) (we) last saw the deceased alive on Jan 27 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did! (did not) view the body after death.

22b. SIGNATURE, DEGREE: [signature] — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Azad J. Vosger, MD

22e. ADDRESS: 10000 Falls Road, Potomac, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-2-1989	Gate of Heaven Cemetery	Sil. Spr. Montgomery Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home	11800 N.H. Ave., Sil. Spr. Md.	FEB 01 '89	Julia Davidson-Randall

BP 15

DHMH - 16 60M 7/84
(VRA 15, 4)

025358 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 05395

1. DECEASED NAME (TYPE OR PRINT) First: Lucille	Middle: E.	Last: Casteel	2a. DATE OF DEATH Month/Day/Year: February 20, 1989		2b. HOUR: 11:05 pm
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH Month/Day/Year: JULY 31, 1935	6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery		MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY: DELIVERY SER.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	MONTGOMERY	ROCKVILLE	YES ☒ NO ☐	12630 VIERS MILL RD. #1608 20853

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
RODNEY E. RICE	ANNA AUGUSTA LENZ	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	--------	229-42-4837	DONNA M. BURKE	3200 WEEPING WILLOW CT. #43 SILVER SPRING, Md. 20906

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Breast Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Hyperkalemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY Hour A.M. P.M. / Month / Day / Year 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION Street / City or Town / County / State

22a. I certify that (I) (~~this hospital~~) attended the deceased from JAN. 19 85, to 2/20 19 89, that (I) (we) last saw the deceased alive on 2/20 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Jules R. Lodish	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jules R Lodish MD	2901 Olney-Sandy Spring Rd. Olney 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION City or Town / County / State
BURIAL	2-23-1989	PARKLAWN CEMETERY	ROCKVILLE, MONTG. CO., MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO. INC.	SILVER SPRING, Md. 20910	FEB 22 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

023389 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05396
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Yes," item 18 should show any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by Dr. John S. Rogers Deputy M.E. 1/31/89

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN	MIDDLE: W.	LAST: CASTELLANO	2a. DATE OF DEATH MONTH DAY YEAR: JANUARY 29 1989	2b. HOUR: 3 30 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 29 1920	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE NURSING CENTER	12a. USUAL OCCUPATION (TYPE OR WORK DONE DURING MOST OF WORKING LIFE): Retired parts Distributor	12b. KIND OF BUSINESS OR INDUSTRY: Utilites Company		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Poolesville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 17662 Kohlhoss Road 20837	
14. FATHER'S NAME FIRST: Ralph	MIDDLE:	LAST: Castellano	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE:	LAST: Hamilton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 114-10-0372	17. INFORMANT: John R. Castellano (son)	ADDRESS: 195 Elmwood Ave. Bogota, New Jersey 07603	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Arts Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan. 13, 1989, to Jan. 29, 1989, that (I) (we) last saw the deceased alive on Jan. 29, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 1-29-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): FRANK LISTELLO, MD — 22e. ADDRESS: 9701 Medical Center Drive Rockville, Md. 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/1/89	23c. NAME OF CEMETERY OR CREMATORY: George Washington Memorial Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Paramus, New Jersey	
24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home, Inc. ADDRESS: 1331 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR: JAN 31 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 104

DHMH - 16 60M 7/84
(VRA 15, 4)

125360 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05397
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health & Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 124

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
John	nmn	Catchuce	Feb. 21, 1989	7:30 a.m.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	Sept. 14, 1919	69 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Masschusetts	U.S.A.		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	520 College Parkway	Retired	U.S.Navy

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Rockville	YES X NO ☐	520 College Parkway 20850

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Fred		Catchuce	Mary		Katerinovich

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1938 - 1968	031-30-0162	Mary Eliz. Catchuce (wife)	same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Renal Cell Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 mos

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/17, 19 88, to 2/21, 19 89, that (I) (we) last saw the deceased alive on 2/6, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Jules R. Lodish MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN X	2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jules R. Lodish	23010 Ney Sandy Spring Rd Olney, Md 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/24/89	Arlington National Cemetery	Arlington, Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852	FEB 22 '89	Julia Davidson-Randall

023764 FEB 26 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 053993

1. DECEASED NAME (TYPE OR PRINT): First Violet; Middle Jessee; Last Catron

2a. DATE OF DEATH: Month 2; Day 20; Year 89

2b. HOUR: 2225 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Month July; Day 8; Year 1927

6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: American

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montg.

13c. CITY OR TOWN: Germantown

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 19355 Archdale Road 20874

14. FATHER'S NAME: First Nelson; Middle C.; Last Jessee

15. MOTHER'S MAIDEN NAME: First Mamie; Middle L.; Last Clark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 231-24-7170

17. INFORMANT: William R. Catron ADDRESS: Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SUDDEN CARDIAC DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): VENTRICULAR FIBRILLATION

DUE TO, OR AS A CONSEQUENCE OF (c): ACUTE MYOCARDIAL INFARCTION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark Freemoker MD DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/21/1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Mark F. Wainskin MD

22e. ADDRESS: 9715 Medical Center Dr., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/23/1989

23c. NAME OF CEMETERY OR CREMATORY: Upper Seneca Cem.

23d. LOCATION: CITY OR TOWN Germantown; COUNTY Montg.; STATE Md.

24. FUNERAL DIRECTOR: NAME Olin L. Molesworth, P.A., ADDRESS Damascus, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 22 1989

25b. REGISTRAR'S SIGNATURE: Wardson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024800 MAR -7 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 053999

1. DECEASED NAME (TYPE OR PRINT) FIRST: ELIZABETH	MIDDLE: L. HUANG	LAST: CHOW	2a. DATE OF DEATH MONTH: 02 DAY: 15 YEAR: 89	2b. HOUR: 0045 M	
3. SEX: Female	4. RACE: Oriental	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 7, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South America	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Takoma Park	YES ☒ NO ☐	7620 Maple Ave., #429 20912

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
M.	W.	Huang	K.	L.	Liu

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	----------	219-68-5951	4811 Nicholson Street William C. Cable, Riverdale, Md. 20737

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (c): Renal failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 1.6.89

22a. I certify that (I) (this hospital) attended the deceased from 2.7. 19 89, to 2.15 19 89, that (I) (we) last saw the deceased alive on 2.14 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: V. Singh DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2.15.89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. SINGH

22e. ADDRESS: 5637 Anna Johns Rd #9 Bladensburg MD 2071-

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-17-89	Ft. Lincoln Cemetery	Brentwood, P.G., Maryland

24. FUNERAL DIRECTOR: FRANCIS GASCH'S SONS FUNERAL HOME.P.A. 4739 Baltimore Ave., Hyattsville, Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 21 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson Registrar

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(6)

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023133 FEB 17 90

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005400

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Harry — MIDDLE: — LAST: Cisenfeld.

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — MONTH: Feb. DAY: 11 YEAR: 1989 — 2b. HOUR: 9:16 AM

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH Feb DAY 22, YEAR of 82 — 6. AGE (IN YEARS LAST BIRTHDAY): YRS. — IF UNDER 1 YR. MONTHS: DAYS: — IF UNDER 24 HRS. HOURS: MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 11 YEAR 1989 — 2d. HOUR: 9:16 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? U. S. A.

8. MARRIED ☐ NEVER MARRIED XXXX WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Si. Spg.

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman

12b. KIND OF BUSINESS OR INDUSTRY: Automobiles

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Sil. Spg. — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 2010 Thayer Ave. # 1032

14. FATHER'S NAME — FIRST: Charles — MIDDLE: — LAST: Cisenfeld

15. MOTHER'S MAIDEN NAME — FIRST: Tobie — MIDDLE: — LAST: Greenfield

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 577-03-4196

17. INFORMANT — ADDRESS: Gladys E. Walker (Same as # 13)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Inf.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐,

ACTUAL SIGNATURE: John S. Rogers, M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Feb. 12, 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M. D. ADDRESS: 1919 Seminary Road, Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2/16/1989 — 23c. NAME OF CEMETERY OR CREMATORY: Rosedale Cemetery — 23d. LOCATION CITY OR TOWN: Baltimore, COUNTY STATE: Maryland

NAME AND ADDRESS OF FUNERAL DIRECTOR: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE RECD. BY REGISTRAR: FEB 15 1989 — 25b. REGISTRAR'S SIGNATURE: G. Gordon Pendell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0253971 Mar 16-89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05401
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Marjorie	Middle: Olive	Last: Cockerill	2a. DATE OF DEATH Month: Feb. Day: 18 Year: 1989	2b. HOUR 5:43P	M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH Month: October Day: 8 Year: 1925	6. AGE (IN YEARS LAST BIRTHDAY) ~~64~~ 63 YRS	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): England	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES XX NO ☐	526 Rutgers Street / 20850

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Gordon / Harry / Martin	Grace / / Sloggett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-	570-42-1521	Patricia C. Thomas, Daughter, Malbone Hall, Newport, Rhode Island 02840

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Septic Shock — Approximate interval between onset and death: 3 hours.

DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonic infiltration right upper lung. — 1 day.

DUE TO, OR AS A CONSEQUENCE OF (c): Lung.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Steroid diabetes (2) Multiple Sclerosis (3) Decubitus ulcer.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐ ☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 89 to 2/18 19 89, that (I) (we) last saw the deceased alive on 2/18 19 89, and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.

22b. SIGNATURE AND DEGREE: J. Blaine Fitzgerald M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. Blaine Fitzgerald, M.D.	8218 Wisconsin Avenue Bethesda, Maryland 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	February 20, 1989	Montgomery Crematorium	Bethesda / / Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland	FEB 21 '89	Julia Davidson-Randall

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

024780 MAR-7 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP 3

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 05402

1. DECEASED NAME (TYPE OR PRINT) FIRST: Margaret	MIDDLE	LAST: Coleman	2a. DATE OF DEATH MONTH DAY YEAR: February 18, 1989	2b. HOUR: 12:21 PM	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: Apr 24, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Mont.	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: 526 So. Hampton St 20903	
14. FATHER'S NAME FIRST MIDDLE LAST: Stamford Crump			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Annie Boykin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 324-38-1673	17. INFORMANT ADDRESS: Cecelia Coleman/dau-in=law/ 1 Appleby Ct. Silver Spring MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Accute Cardiorespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): Accute Occlusive Vascular disease of legs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from Feb 13 19 89 to Feb 18 19 89, that (I) (we) last saw the deceased alive on Feb 17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Elba Martinez MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 19 Feb 89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Elba Martinez MD	22e. ADDRESS: 8808 Hidden Hill Lane, Potomac, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-21-89=	23c. NAME OF CEMETERY OR CREMATORY: Harmony MEMORIAL PK	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Landover PG MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: Marshall's Funeral Home, Inc. 4217 9th St., NW Washington, DC		25a. DATE REC'D. BY REGISTRAR: MAR 2 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024210 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 054003

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Lola — MIDDLE: — LAST: Colonell

2a. DATE OF DEATH — MONTH DAY YEAR: 2-21-89

2b. HOUR: 10A M (30)

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: 10-24-07

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Persia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CIA Analyist

12b. KIND OF BUSINESS OR INDUSTRY: US Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Mont

13c. CITY OR TOWN: S.S.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 410 Whitestone Road 20901

14. FATHER'S NAME — FIRST: Antoine — MIDDLE: — LAST: Volkoff

15. MOTHER'S MAIDEN NAME — FIRST: Helene — MIDDLE: — LAST: Kinshina

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 220 44 1184

17. INFORMANT — ADDRESS: 7826 Eastern Ave.N.W.: Samuel Markowitz (Attorney)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis - liver, lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma sigmoid colon — 1± years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anemia, slowing GI blood loss, diabetes mellitus, hypertensive dz

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-72 to 2-21 19 89, that (I) (we) last saw the deceased alive on 2/20 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (took) (did not) view the body after death.

22b. SIGNATURE: J. Frederick Barr M — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr.J. Frederick Barr

22e. ADDRESS: 4500 College Ave. College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/24/89

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION — CITY OR TOWN: Rockville — COUNTY: Mont — STATE: Md.

24. FUNERAL DIRECTOR — NAME: Hines Rinaldi — ADDRESS: 11800 New Hamp. Ave

25a. DATE REC'D. BY REGISTRAR: FEB 23 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

0240 90 FEB 28 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 054044

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
VACILIKI	C.	CONDELES	FEBRUARY 8, 1989	10:55A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	CAUCASIAN	JAN 1 1908	81 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
GREECE	USA		MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
KENSINGTON	3711 NIMITZ ROAD	RESTAURATEUR	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	KENSINGTON	YES ☐ NO ☐	3711 NIMITZ ROAD 20895

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ELIAS		BARTZIS	ELENI		UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		236-34-2637	THEODORA C. KOUTRIS/DAUGHTER/SAME AS 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) hepatic failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) colon carcinoma — 13 months

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
N/A	N/A	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT, WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
N/A	N/A	N/A

21d. INJURY OCCURRED WHILE AT WORK	NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
		N/A	N/A			

22a. I certify that (I) this hospital) attended the deceased from 10/23 19 87, to 2/8 19 89, that (I) (we) last saw the deceased alive on 1/16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Kathryn Kirwin	MD	☐ ☒ ☐	2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
KATHRYN KIRWIN, M.D.	10400 CONNECTICUT AVE #606 KENSINGTON, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	FEB 10, 1989	GATE OF HEAVEN CEM.	SILVER SPRING	MONT	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 13 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

025351 MAR 16 89

FOR D. OF STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05405
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: OMAR	MIDDLE: L	LAST: CORNELIUS	2a. DATE OF DEATH MONTH: 2	DAY: 18	YEAR: 89
2b. HOUR: 215 P M					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 12	DAY: 11	YEAR: 34	6. AGE (IN YEARS LAST BIRTHDAY): 54 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): How Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): POLICE OFFICER	12b. KIND OF BUSINESS OR INDUSTRY: MONT COUNTY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [XX]	243 HANNES STREET 20901

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
GEORGE	ROBERT	CORNELIUS	HELEN		GILLEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	1958-1961	577-46-2869	E. BERNICE CORNELIUS/WIFE/SAME AS 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immed

DUE TO, OR AS A CONSEQUENCE OF (b): Lymphoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2/18, 19 89, that (I) (we) last saw the deceased alive on 2/18, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Aron Primack	MD	ATTENDING PHYSICIAN [X]	MEDICAL DIRECTOR [ ]	STAFF PHYSICIAN [ ]	2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ARON PRIMACK, M.D.	2101 MEDICAL PARK DR. #211 SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 21, 1989	PARKLAWN CEMETERY	ROCKVILLE MONTGOMERY MARYLAND

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 22 '89	Julia Davidson-Randall

BP 1441

DHMH - 16 50M 1/81 (VRA 15, 4)

025339 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05406 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Genevieve	MIDDLE: Williamson	LAST: Cremins	2a. DATE OF DEATH MONTH DAY YEAR: February 21, 1989	2b. HOUR: 7:50 PM	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: November 19,1895	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Retirement & Nursing Ctr.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Chevy Chase	YES ☒ NO ☐	4716 Dorset Avenue 20815

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
William / / Williamson	Helen / / Burlingame

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Son) ADDRESS
No		578-32-8447	James Cremins, 8905 River Road, Richmond, Virginia 23229

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIO-RESPITORY FAILURE	72 Hours
DUE TO, OR AS A CONSEQUENCE OF (b)	GENERALIZED ARTERIOSCLEROSIS	20 Years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PNEUMONIA AND DEHYDRATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from October 28, 19 85 to February 21, 19 89 that (I) (we) last saw the deceased alive on February 21, 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb. 22, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John M. Wyman, M.D.	7801 Norfolk Avenue, Bethesda, MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 23, 1989	Parklawn Memorial Park	Rockville/Montgomery/Maryland

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814	FEB 24 '89	Gisha Davidson-Kendall

BP 8

DHMH - 16 60M 7/84
(VRA 15, 4)

24642 MAR -3 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05407 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
ELVA	JEAN	CROSSE	02	19	89	0455a M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	CAUCASIAN	04 29 1930	58 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
PA	US		MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	BETHESDA NAVAL HOSPITAL	RETIRED	CIVIL SERVICE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	CECIL	ELKTON	YES ☐ NO ☒	FLETCHWOOD RD 2927

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
SAMUEL	HOWARD	SMITH	ALBERTA		GRAHAM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES		175-24-5510	FRED CROSSE	1055 RIDGE RD RISING SUN MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) LUNG CA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 13 FEB 1989, to 19 FEB 1989, that (I) (we) last saw the deceased alive on 19 FEB 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
C.A. Thompson	MD	☐ / ☐ / ☒	19Feb89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C.A. THOMPSON	BETHESDA NAVAL HOSPITAL, BETHESDA, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-23-89	BROOKVIEW Cemetery	Rising Sun Cecil MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RCVD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ROBERT FOARD	RISING SUN, MD	FEB 21 89	

Richard L. Goodke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21a is marked, or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10 1 V.A.

DHMH - 16 50M 1/81 (VRA 15, 4)

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4 1 V 1
qmc

025297 MAR 1 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05403
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert	MIDDLE: J	LAST: Cummings	2a. DATE OF DEATH MONTH: 02	DAY: 14	YEAR: 89
2b. HOUR: 11:44 A M					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 7	DAY: 20	YEAR: 25	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co	MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Budget Analyst	12b. KIND OF BUSINESS OR INDUSTRY: Fed. Gov't.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: MD	13b. COUNTY: Montg.	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 902 Winhall Way. 20904	
14. FATHER'S NAME FIRST: James	MIDDLE: Walter	LAST: Cummings	15. MOTHER'S MAIDEN NAME FIRST: Anna	MIDDLE: -	LAST: O'Malley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): W.W. II	16b. SOCIAL SECURITY NO.: 190-14-2101	17. INFORMANT: Frances L. Cummings	ADDRESS: Same as #13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from February 7 19 89 to February 14 19 89, that (I) (we) last saw the deceased alive on February 14 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry Lyle MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-14-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Henry Lyle — 22e. ADDRESS: 8830 Cameron St. Silver Spring MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/18/89	23c. NAME OF CEMETERY OR CREMATORY: ST. PATRICK CEM.	23d. LOCATION CITY OR TOWN: Blakely	COUNTY: Lackawanna	STATE: Pa.

24. FUNERAL DIRECTOR NAME: W.W. Chambers Co. Inc. ADDRESS: 5801 Cleveland Ave Riverdale Md. — 25a. DATE REC'D. BY REGISTRAR: FEB 16 '89 — 25b. REGISTRAR'S SIGNATURE: Gwendolyn Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN retained by the hospital or attending phy

TO FUNERAL DIRECTOR: After this certific should be detached for use as the burial-trc with the State Dept. of Health and Mental H

IMPORTANT: If Item 21 is marked or Item 18

DIVISION OF V

E. MARYLAND 21201

completely filled in by the funeral director, page 3 i 1-and 2 should be filed within 72 hours after death

ated within 24 hours after death. Page 4 may be

physician must be notified at once

Hard this 3/24 till we receive request for 5 more copies + $15.00 (copies to this office and will mail ck.

BP 4 + 1 grafts

DHMH - 16 50M 1/81 (VRA 15, 4)

023368 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05409
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: DEAN C. CUSHING				2a. DATE OF DEATH MONTH DAY YEAR: 01 26 89	2b. HOUR: 6:10 PM
3. SEX: M	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: 05 03 1922	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW HAMPSHIRE	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MONTGOMERY GENERAL HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LEGIS. ANALYST	12b. KIND OF BUSINESS OR INDUSTRY: STATE OF MASSACHUSETTS		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [X]	3503 SO. LEISURE WORLD BLVD.	20906

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
ABRAHAM / / CUSHING	ANNE / / CROWLEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	001-12-5796	ANNETTE CUSHING	WIFE SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Aspiration	
DUE TO, OR AS A CONSEQUENCE OF (c)	Myasthenia Gravis	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Metastatic Cancers, suspected Coronary Artery Disease and Hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
[ ]	19	

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/26, 19 89, to 1/26, 19 89 that (I) (we) last saw the deceased alive on 1/26, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not) view the body after death.

22b. SIGNATURE: John Yackee — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Yackee MD

22e. ADDRESS: 380 INTERNATIONAL DRIVE SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	JAN. 30, 1989	GATE OF HEAVEN	SILVER SPRING MONTGOMERY MD.

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR.
ADDRESS: 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901

25a. DATE REC'D. BY REGISTRAR: JAN 30 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 201

DHMH - 16 50M 1/81 (VRA 15, 4)

022413 FEB 13 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 05410

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ABRAHAM; MIDDLE: ; LAST: DANZIG				2a. DATE OF DEATH MONTH 2 DAY 4 YEAR 89	2b. HOUR 7 P.M.
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH MAY DAY 12 YEAR 1899	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): RUSSIA	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME OF GREATER WASHINGTON	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MERCHANT	12b. KIND OF BUSINESS OR INDUSTRY: LIQUOR		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES [X] NO [ ]	10309 LESLIE STREET 20902

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: SOLOMON; MIDDLE: ; LAST: DANZIG	FIRST: ANNA; MIDDLE: ; LAST: (UNASCERTAINABLE)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		579 36 6180	A. BEVERLY PORTER,	10309 LESLIE STREET SILVER SPRING, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ASPIRATION PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): MULTI-INFARCT DEMENTIA

DUE TO, OR AS A CONSEQUENCE OF (c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
[ ]		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]					

22a. I certify that (I) (this hospital) attended the deceased from 8/19/87 to 2/4/89, that (I) (we) last saw the deceased alive on 2/4/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
D. D. PATEL	6121 MONTROSE RD ROCKVILLE, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2/7/1989	MOUNT LEBANON CEMETERY	ADELPHI,	PR. GEO.,	MARYLAND

24. FUNERAL DIRECTOR (NAME AND ADDRESS)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.	FEB 8 1989	Julia Davidson-Randall

BP____

DHMH - 1650M 1/81 (VRA 15, 4)

024696 MAR-3 '89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

18 FOR STATE REGISTRAR: ANNA E. DAVIS

89 05411 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove entire page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Anna	MIDDLE: E.	LAST: DAVIS	2a. DATE OF DEATH MONTH DAY YEAR: 2 25 89	2b. HOUR: 630 A M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 2 27 88	6. AGE (IN YEARS LAST BIRTHDAY): 100 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: GAITHERSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOSPITAL SUPERVISOR	12b. KIND OF BUSINESS OR INDUSTRY: HOSPITAL
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: Anne Arundel	13c. CITY OR TOWN: Hanover	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 7862 Ridge Road 21076
14. FATHER'S NAME FIRST: SAMUEL	MIDDLE: -	LAST: WEBER	15. MOTHER'S MAIDEN NAME FIRST: IDA	MIDDLE: - LAST: BARLETT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	IF YES, GIVE WAR OR DATES:	16b. SOCIAL SECURITY NO.: 217-34-3593	17. INFORMANT: ROLAND E. DAVIS	6061 Aldershot Rd. Baltimore, Md. 21229

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 7-1, 19 87, to 2-25, 19 89, that (I) (~~was~~ last saw the deceased alive on 2-23, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~was~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: John Tauber	DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-25-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Tauber	22e. ADDRESS: 8218 Wisconsin Ave Bethesda MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: FEB. 25, 1989	23c. NAME OF CEMETERY OR CREMATORY: BALT. WASH. CREMATORY	23d. LOCATION CITY OR TOWN: LAUREL	COUNTY: P.GEORGE STATE: MD.
24. FUNERAL DIRECTOR NAME / ADDRESS: MURIEL H. BARBER LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR: 3-1-89	25b. REGISTRAR'S SIGNATURE:	

022970 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05412
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT - If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY; MIDDLE: ROADS; LAST: DAVIS			2a. DATE OF DEATH MONTH DAY YEAR: 2-4-1989	2b. HOUR: 7:32 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 6 05 03	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Book Store Cashier	12b. KIND OF BUSINESS OR INDUSTRY: University of Maryland	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: College Park	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 6304 Tecumseh Place 20740
14. FATHER'S NAME FIRST: John; MIDDLE: Q.; LAST: Roads		15. MOTHER'S MAIDEN NAME FIRST: Carrie; MIDDLE: [illegible]; LAST: McMullen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-42-5498	17. INFORMANT: (Son) William R. Davis	ADDRESS: 1947 High Ridge Road Annapolis, Md. 21401

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SEPTIC SHOCK — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): ASPIRATION PNUMONIA

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (c): CVA / Coronary Artery Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Congestive Cardiac Failure / Renal Failure

19a. DATE OF OPERATION: X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: X	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ X NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): X	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET: ✓ CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-28-1989 to 2-4-1989, that (I) (we) last saw the deceased alive on 2-4-1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A Qadri — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ASIF S. QADRI

22e. ADDRESS: 4700 - BERWYN HOUSE RD, COLLEGE PK

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/07/89	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN: Brentwood; COUNTY: P.G.; STATE: Maryland	
24a. FUNERAL DIRECTOR NAME: Francis Casch's Sons Funeral Home, P.A. ADDRESS: 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR: FEB 9 '89	25b. REGISTRAR'S SIGNATURE: Juha Davidson-Randall	

0224 21 FEB 13 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05413 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please [illegible] pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other [illegible] the medical examiner must be notified of the [illegible]

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ANTHONY	MIDDLE: (NMN)	LAST: DAVIS JR.	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 3, 1989	2b. HOUR: 8:05P.M.	
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: MARCH 6, 1986	6. AGE (IN YEARS LAST BIRTHDAY): 2 YRS	IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY	MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NIH, THE CLINICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY	13c. CITY OR TOWN: BALTIMORE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 2409 DUMFRIES COURT 21230	
14. FATHER'S NAME FIRST: Anthony	MIDDLE	LAST: Davis, Sr	15. MOTHER'S MAIDEN NAME FIRST: Annette	MIDDLE	LAST: Bennett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: N/A	17. INFORMANT: MRS. ANNETTE BENNETT	ADDRESS: 2409 DUMFRIES COURT BALTIMORE, MD 21230	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: WEEKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) AUTOIMMUNE DEFICIENCY SYNDROME — MONTHS

DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMOCYSTIS CARINII PNEUMONIA — MONTH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that ☒ (this hospital) attended the deceased from December 13 19 88, to FEBRUARY 3 19 89, that ☒ (we) last saw the deceased alive on FEBRUARY 3 19 89, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED: 4 Feb 89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE DANIEL MARTICH	22e. ADDRESS: NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial (Removal)	23b. DATE: 2-7-89	23c. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park	23d. LOCATION CITY OR TOWN: Baltimore COUNTY: Md.	STATE
24. FUNERAL DIRECTOR NAME: Marshall's Funeral Home MFH ADDRESS: 4217 9th St NW: Washington, D.C. West	25a. DATE REC'D. BY REGISTRAR: FEB 08 1989	25b. REGISTRAR'S SIGNATURE: [signature]		

022774 FEB 15 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05414
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Fairy	MIDDLE: L.	LAST: Day	2a. DATE OF DEATH MONTH DAY YEAR: 2-9-89	2b. HOUR: 330 P M
3. SEX: Female.	4. RACE: White.	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 6 1922	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Jamsville MD.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery. MD.	
10. CITY OR TOWN OF DEATH: Rockville.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Hospital.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cafet. Schools	12b. KIND OF BUSINESS OR INDUSTRY: Montg. Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Montg.	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 715 Chesapeake Ave. 20910
14. FATHER'S NAME FIRST MIDDLE LAST: Dorsey E. Lawson.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Nellie I. Watkins.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No.	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219-12-0844	17. INFORMANT ADDRESS: Earl F. Day. (13 e)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC ESOPHAGEAL CARCINOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 mos
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
HYPERTENSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from DECEMBER, 1987, to FEBRUARY 9, 1989, that (I) (~~we~~) last saw the deceased alive on FEBRUARY 8, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: James A. Brown MD	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES A. BROWN, MD	22e. ADDRESS: 14808 PHYSICIANS LANE #212 ROCKVILLE MD. 20850	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial.	23b. DATE: Feb. 13 1989	23c. NAME OF CEMETERY OR CREMATORY: Colesville.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Colesville, Montg. Co, Md
24. FUNERAL DIRECTOR NAME / ADDRESS: Arthur Walters. Takoma Funeral Home. 254 Carroll St. N. W. D C	25a. DATE REC'D. BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

24098 FEB 28 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05415
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Marilyn	MIDDLE: Marie	LAST: Day	2a. DATE OF DEATH MONTH DAY YEAR: 02/10/89	2b. HOUR: 10:41 AM	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: February 23, 1947	6. AGE (IN YEARS LAST BIRTHDAY): 41 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES ☐ NO ☐	817 Malta Lane 20901

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Walter	L.	Day	Marie	H.	Casey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		219-48-9394	Walter L. Day Father	Same as 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	acute cardiorespiratory arrest	1 day
DUE TO, OR AS A CONSEQUENCE OF (b)	aspiration pneumonia	5 days
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/9 19 89 to 2/10 19 89, that (I) (we) last saw the deceased alive on 2/10 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Myron L Lenkin DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MYRON L. LENKIN 22e. ADDRESS: 2309 SHOREFIELD RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 13, 1989	Gate of Heaven	Silver Spring Montgomery Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md. 20901	FEB 13 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

123466 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 054116

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jean Paul	MIDDLE	LAST: DeBlois	2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH: 2 DAY: 14 YEAR: 89	2b. HOUR: 1128 A.M. ☐ P.M. ☒			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 8, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH: 2 DAY: 16 YEAR: 1989	2d. HOUR: 1128 A.M. ☐ P.M. ☒
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Rhode Island	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Consultant	12b. KIND OF BUSINESS OR INDUSTRY: Pvt. Security				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Virginia	13b. COUNTY: Fairfax	13c. CITY OR TOWN: McLean	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 6702 Lumsden Street			
14. FATHER'S NAME FIRST MIDDLE LAST: Jean Baptiste DeBlois		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Rose Marie Granger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 036-14-6038	17. INFORMANT ADDRESS: Jacqueline DeBlois/Wife/ 6702 Lumsden St., McLean, Va. 22101				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Ventricular Fibrillation	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary artery Disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-16-89

EXAMINER'S NAME (TYPE OR PRINT): John Tauber ADDRESS: 8218 W. Wisconsin Ave, Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb. 17, 1989	Metropoliton Crematory	Alexandria, Fairfax, Va.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Money & King Funeral Home, 171 W. Maple Ave. Vienna, Va. 22180	FEB 21 1989	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE USING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 75M BP

DHMH - 17 (VR A15 ME (5))

024064 FEB 23

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005417

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

1. DECEASED NAME (TYPE OR PRINT) First: James Middle: Vincent Last: DeMauro, Jr. (JAMES Vincent DEMAURO, Jr.)	2a. DATE OF DEATH Month: 2 (FEB) Day: 16 Year: 1989	2b. HOUR: 4:00 P M		
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH Month: May Day: 13 Year: 1953	6. AGE (IN YEARS LAST BIRTHDAY): 35 YRS.	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): England	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10013 Quinby Court	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Computer Programmer	12b. KIND OF BUSINESS OR INDUSTRY: Consulting	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	10013 Quinby Court / 20901

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
James / Vincent / DeMauro, Sr.	Anita / C. / Fiore	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT / ADDRESS**
No	018-44-5100	Linda Allan, 3202 18th Street, NW Washington, DC 20009

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	ENCEPHALOPATHY	
DUE TO, OR AS A CONSEQUENCE OF (c)	AIDS (Acquired Immune Deficiency Syndrome)	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hepatic Disease, Mycobacterium Avium Intracellulare

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 88 to FEBRUARY 19 89, that (I) (we) last saw the deceased alive on 2/15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
William B. Furlong	MD	☐ ☑ ☐	2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William B. Furlong M.D.	8830 CAMERON ST. #503 Silver Spring Md. 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-22-89	Woodlawn Crematory	Everett, Massachusetts

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910	FEB 23 1989	Julia Davidson-Kendall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025334 MAR 1 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B REG. NO. 054139

1. DECEASED NAME (TYPE OR PRINT) First: Werner Middle: F.H. Last: Dannemann				2a. DATE OF DEATH Month Day Year: 2-22-89	2b. HOUR: 540 PM
3. SEX: Male M	4. RACE: White C	5. DATE OF BIRTH Month Day Year: 8 18 30		6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Germany	7b. CITIZEN OF WHAT COUNTRY?: W. Germany	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ECONOMIST	12b. KIND OF BUSINESS OR INDUSTRY: IMF
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Montgomery	13c. CITY OR TOWN: POTOMAC	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 9408 WARDEN CT 20854	
14. FATHER'S NAME First: Walter Middle: Last: Dannemann			15. MOTHER'S MAIDEN NAME First: Else Middle: Last: Boening		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT ADDRESS: Jutta G.E. Dannemann Same as item # 13		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEPATIC CIRRHOSIS — 1 year
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/20 19 89 to 2/22 19 89, that (I) (we) last saw the deceased alive on 2/22 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
R Lind MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ROBERT J. LINDEMAN MD	10215 Fernwood Rd. Beth., MD 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/28/89	Mt. Comfort Crematory	Alex., VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 WI Ave, NW Wash., DC 20016	FEB 24 '89	Jutta Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

025335 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05419
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	ELIZABETH Simms DAVIS	2a. DATE OF DEATH — MONTH / DAY / YEAR	02 21 89	2b. HOUR	11:50 M
3. SEX	Female	4. RACE	Black	5. DATE OF BIRTH — MONTH / DAY / YEAR	JAN. 26, 1894
6. AGE (IN YEARS LAST BIRTHDAY)	95 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH	Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Montg.	Silver Spring	YES ☐ NO ☐	2815 Lyttonsville Rd, #104 20910

14. FATHER'S NAME — FIRST / MIDDLE / LAST	FRED Simms	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	UNK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		213-18-6587	Pamela Christian	3917 Hampden St Kensington, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal Bleed

DUE TO, OR AS A CONSEQUENCE OF (c) Gastric Ulcer.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) — (b) wks. (c) wks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Old age.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 89, to 2/22 19 89, that (I) (we) last saw the deceased alive on 2/21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Alison Davis	MD	☐ ☑ ☐	2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ALISON DAVIS	14915 Braschart Rd. Rockville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	2-27-89	Ash Memorial Cem.	Sandy Spring, Montg., MD

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George R. Snowden Rockville, MD 20850	FEB 24 '89	Julia Davidson-Randall

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

025348 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05420
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Barbara MIDDLE: W. LAST: Dassori BARBARA W. DASSORI			2a. DATE OF DEATH MONTH DAY YEAR: 2 15 89	2b. HOUR: 5:56 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 3 10 09	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Montgomery	Kensington	YES [X] NO [ ]	9628 Hawick Lane/20895

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
John George Weisser	Barbara Sauer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	---	212-74-7393	Frederic D. Dassori, Same address as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Aspiration Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CVA (Cerebrovascular Accident)

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/9/ 19 89, to 2/15/ 19 89, that (I) (we) last saw the deceased alive on 2/15/89 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Galen Hallick	MD	[ ] [X] [ ]	2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GALEN HALLICK	11125 Rockville Pike Rockville, Md 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-21-89	Mt. Comfort Crematory	Alexandria, VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016	FEB 22 '89	Julia Davidson-Randall

025345 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05421
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Evelyn	MIDDLE: Elizabeth	LAST: Dillstrom	2a. DATE OF DEATH MONTH DAY YEAR: 02 16 89	2b. HOUR: 0312 M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Sept 14, 1916	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dietician	12b. KIND OF BUSINESS OR INDUSTRY: Health Care		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Gaithersburg	YES ☒ NO ☐	9910 Walker House Rd, #3 20879

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Elmer	Bruce	Dillstrom	Elizabeth		Burbank

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		060-16-0057	Janet Wrieden	1513 S.E. 12th Street Deerfield Beach, FL

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis	
DUE TO, OR AS A CONSEQUENCE OF (b)	Renal Failure	
DUE TO, OR AS A CONSEQUENCE OF (c)	Lymphoma.	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
NA		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 2-2 19 89, to 2-16 19 89, that (I) (we) last saw the deceased alive on 2-13-89 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2.16.89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): T.J. McNAMARA

22e. ADDRESS: 9642 Clubhouse Rd Gaithersburg, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	19 FEB 89	Metropolitan	Alexandria Virginia

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DeVol Funeral Home	10 E. Deer Pk Dr Gaithersburg, MD	FEB 22 '89	Julia Davidson-Randall

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

025356 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005422

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	MARY / R. / DIMICHELE	2a. DATE OF DEATH MONTH DAY YEAR	2-16-89	2b. HOUR	838 M
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	1-25-11
6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH	SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	PR GEORGES	HYATTSVILLE	YES ☐ NO ☐	5905 SARGENT ROAD 20782

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
JOSEPPE / / PASSANTE	MADELINE / / ANGELCANTO

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		578-30-1051	SON ALBERT C. DiMICHELE	11410 BRANDYWIND RD CLINTON, MD 20735

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory arrest	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebrovascular accident	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes mellitus, Coronary Artery Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1982, 19__, to 2/16, 19 89, that (I) (we) last saw the deceased alive on 2/16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Irnest Oser	MD		2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
IRNEST OSER, M.D.	10301 GEORGIA AVE. #304 SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 21, 1989	GATE OF HEAVEN CEM.	SILVER SPRING MONT MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 22 '89	Julia Davidson-Randolph

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be signed by the attending physician and completely filled in by the funeral director, page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 25

DHMH - 16 50M 1/81 (VRA 15, 4)

024151 FEB 29 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 05423

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Provvidenza	MIDDLE	LAST: Disalvo	2a. DATE OF DEATH MONTH DAY YEAR: 2-4-1989	2b. HOUR: 15 4 A M
3. SEX: Female	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 10 19 1900	6. AGE (IN YEARS LAST BIRTHDAY): 88 yrs YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): SICILY	7b. CITIZEN OF WHAT COUNTRY?: SICILY	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONT. MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Mont.	Silver Spring	YES ☑ NO ☐	1633 Briggs Chaney Rd. 20904

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
ANTONINO / / LaMENDOLA	GAETANA / / MAUSCIOTTO

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		215-54-6948	ROSALIA BRESCHI/DAUGHTER/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOVASCULAR COLLAPSE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): HYPERTENSIVE PULMONARY HEART DISEASE

DUE TO, OR AS A CONSEQUENCE OF (c): SEVERE, TERMINAL, CHRONIC LUNG DISEASE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): arteriosclerotic heart disease - cardiac arrhythmias

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 75, to FEB 4, 19 89, that (I) (we) last saw the deceased alive on FEB 3, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Joseph M Solinas	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JOSEPH M. SOLINAS	9801 GEORGIA AVE. SILVER SPRING, MD 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 7, 1989	GATE OF HEAVEN CEM.	SILVER SPRING MONT MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 06 '89	Julia Davidson-Randolph

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

025085 MAR-9 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05424
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Elsie	MIDDLE: Anna	LAST: Dreisbach	2a. DATE OF DEATH MONTH DAY YEAR: 02-20-89	2b. HOUR: 5:20 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 29, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): German	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): University Conv. & Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Bakery
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Lutherville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 7 Turnberry Court 21093
14. FATHER'S NAME FIRST: Ernest	MIDDLE: A.	LAST: Jente	15. MOTHER'S MAIDEN NAME FIRST: Mathilde	MIDDLE: H. LAST: Meschter
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578-36-1721	17. INFORMANT (Niece) 7 Turnberry Court ADDRESS: Edith Elliott Lutherville, Maryland 21093	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

(IMMEDIATE CAUSE (a)) Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Myron L. Lenkin	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Myron L. Lenkin, M.D.	22e. ADDRESS: 2309 Shorefield Road Wheaton, Md. 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/25/89	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN: Brentwood COUNTY: P.G. STATE: Maryland	
24. FUNERAL DIRECTOR (NAME): Francis Gasch's Sons Funeral HOme, P.A. ADDRESS: 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR: FEB 23 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

P.

5

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

025354 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 105425
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: William	MIDDLE	LAST: Drumsta	2a. DATE OF DEATH MONTH: February	DAY: 17,	YEAR: 1989	2b. HOUR: 2:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH / DAY / YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Male	CAUCASIAN	3/ 05/ 16	72 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
PENNSYLVANIA	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General Hospital	BUS DRIVER	METRO

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [X]	520 EDNOR ROAD 20904

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
MARTIN / DRUMSTA	PAULINE / WICHULUS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	170-10-3964	ELIZABETH R. DRUMSTA/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary arrest.	2/17/89 2hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	CHF, Pneumonia, COPD	2/16/89
DUE TO, OR AS A CONSEQUENCE OF (c)	Renal failure	12/88

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Renal failure, Blood lung, dehydration

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
—	—	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	—	—

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	—	—

22a. I certify that (I) (this hospital) attended the deceased from 1/27 19 89, to 2/17 19 89, that (I) (we) last saw the deceased alive on 2/17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Arthur Schoengold MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Arthur Schoengold, M.D.	18101 Prince Phillip Dr Olney, md 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 21, 1989	GATE OF HEAVEN CEM.	SILVER SPRING / MONT / MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 22 '89	Julia Davidson-Randall

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

024294 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05426
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert MIDDLE: F. LAST: Dove		2a. DATE OF DEATH MONTH DAY YEAR: 02-26-89	2b. HOUR: 22:50 P M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 02-24-09	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C	7b. CITIZEN OF WHAT COUNTRY?: United states	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Liaison Rep.	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Greenbelt	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 22 Ridge Rd. # 103 20770
14. FATHER'S NAME FIRST: Howard MIDDLE: M. LAST: Dove		15. MOTHER'S MAIDEN NAME FIRST: Lola MIDDLE: A. LAST: Lucas	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 220-10-5461 A	17. INFORMANT: Kenneth E. Pence (friend) — ADDRESS: 4702 LexingtonAve Belts., Md. 20705	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory arrest, Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic respiratory insufficiency
DUE TO, OR AS A CONSEQUENCE OF (c): Cardiovascular surgery

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic obstructive Pulmonary Disease Recurrent Sepsis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from March, 19 88, to present, 19 ____, that (I) (we) last saw the deceased alive on 2/23/89 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Norton Elson MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Norton Elson MD — 22e. ADDRESS: 6525 Belcrest Rd Hyattsville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 3-1-1989	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory	23d. LOCATION CITY OR TOWN: Alexandria COUNTY: Fairfax STATE: VA	
24. FUNERAL DIRECTOR (NAME): Donald V. Borgwardt	ADDRESS: 4400 Powder Mill Road Beltsville, Md., 20705	25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE: [signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

025391 MAR 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05427
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: LAWRENCE MIDDLE: M. LAST: DOWD		2a. DATE OF DEATH MONTH DAY YEAR: 1-27-89	2b. HOUR: 442 PM
3. SEX: M	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: 8 07 1932	6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASS.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CONSULTANT	12b. KIND OF BUSINESS OR INDUSTRY: GEN. ELEC. CO.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	MONT.	ROCKVILLE	YES [X] NO [ ]	14003 CASTAWAY DR. 20853

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
THOMAS / J. / DOWD	HANNA / M. / DOWD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NONE	014-24-3486	MARY C. DOWD	WIFE SAME AS 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis	120 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	bile duct carcinoma	14 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): esophageal varices

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 22 19 89, to January 27 19 89, that (I) (we) last saw the deceased alive on January 27 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Michael Schindler	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	1/28/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL SCHINDLER MD	1106 Spring Street, Silver Spring MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB. 1, 1989	ST. MICHAELS CEM.	SPRINGFIELD HAMPDEN MASS.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS FUNERAL HOME	SILVER SPRING, MD. 20901 500 UNIVERSITY BLVD. W.	JAN 30 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 1 (the carbonpaper). Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 10-50M 1/81 (VRA 15, 4)

025337 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05423
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE H. LAST Downs JR.

2a. DATE OF DEATH: MONTH 2 DAY 21 YEAR 89

2b. HOUR 0550 M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH June DAY 5 YEAR 1918

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY Grove Adv. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Driver

12b. KIND OF BUSINESS OR INDUSTRY: Transportation

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Germantown

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 13202 Bristolcone Way/20874

14. FATHER'S NAME: FIRST William MIDDLE H. LAST Downs

15. MOTHER'S MAIDEN NAME: FIRST Rose MIDDLE LAST Case

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579 07 7849

17. INFORMANT ADDRESS: Lelia M. Downs, wife, see #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC ADENOCARCINOMA - COLON
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DEHYDRATION / SEPSIS

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/20 19 89 to 2/21 19 89, that (I) (~~saw~~) last saw the deceased alive on 2/21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~saw~~) (did not) view the body after death.

22b. SIGNATURE: G Beckham DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BECKER

22e. ADDRESS: 17904 Georgia Ave, Olney MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 23, 1989

23c. NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery

23d. LOCATION CITY OR TOWN: Gaithersburg COUNTY: Maryland STATE

24. FUNERAL DIRECTOR (NAME): Robert A. Pumphrey Funeral Home-Rockville, Inc. 300 W. Montgomery Ave., Rockville, Md. 20850

25a. DATE REC'D. BY REGISTRAR: FEB 24 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

022318 FEB 10 09

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05429
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Cora		Dubois	February 7,1989	11:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	01/01/02	87 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Canada	U.S.A.		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Adventist Hospital	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
FL		Hollywood	YES ☐ NO ☐	5300 Washington St

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Henri		Harpin	Malvina		Filiatreault

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		035-42-8368	Richard Dubois	51 Brinkwood Rd Brinklow, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov 25 19 88 to 7 Jan 19 89, that I (we) last saw the deceased alive on 7 Jan 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
	MD		8 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Michael Leibowitz	11120 New Hamp. Ave. S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / STATE
Burial	2/11/89	St. John the Baptist	South Bellingham MA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New Hampshire Silver Spring, MD	FEB 09 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the Local Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 1 16.60M 7/84
(VRA 15. 4)

025303 MAR 14 89

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005430
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1. DECEASED NAME (TYPE OR PRINT) FIRST: KEVIN MIDDLE: W. LAST: DURKIN		2a. DATE OF DEATH MONTH: 2 DAY: 12 YEAR: 89	2b. HOUR: 11:45 AM
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: 8 DAY: 14 YEAR: 57	6. AGE (IN YEARS LAST BIRTHDAY): 31 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TEXAS	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RATES SPECIALIST	12b. KIND OF BUSINESS OR INDUSTRY: AM EXPRESS
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN: WASH., DC	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 1508 6TH STREET, NW 99999			
14. FATHER'S NAME FIRST: ROBERT MIDDLE LAST: DURKIN		15. MOTHER'S MAIDEN NAME FIRST: AUDREY MIDDLE LAST: WILMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-80-7628	17. INFORMANT: SISTER MARY RAMOS	ADDRESS: 13240 COPLAND CT. SILVER SPRING, MD 20904

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardiorespiratory arrest	1 minute
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Non-Hodgkin's Lymphoma	3 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Human Immunodeficiency Virus Infection	3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from December 88 to February 12 89, that (I) (we) last saw the deceased alive on February 12 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bruce A. Silver	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/12/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): BRUCE A. SILVER	22e. ADDRESS: 106 IRVING ST, NW, WASH, DC 20010		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 15, 1989	23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.	23d. LOCATION CITY OR TOWN: SILVER SPRING COUNTY: MONT	STATE: MD
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 15 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 20

DHMH-16 50M 1/81 (VRA 15, 4)

024086 FEB 28 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 005431

1. DECEASED NAME (TYPE OR PRINT): Sterling (FIRST) Paul (MIDDLE) Eagleton (LAST)

2a. DATE OF DEATH: Feb. 9 1989 (MONTH DAY YEAR)

2b. HOUR: 3:15p M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: March 2nd 1903 (MONTH DAY YEAR)

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 615 St. Andrews Lane

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer

12b. KIND OF BUSINESS OR INDUSTRY: Art Gallery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13c. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 615 St. Andrews Lane/20901

14. FATHER'S NAME: Clarence E. Eagleton (FIRST MIDDLE LAST)

15. MOTHER'S MAIDEN NAME: Frances Greenisen (FIRST MIDDLE LAST)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): Pre WW II

16b. SOCIAL SECURITY NO.: 214-36-1836

17. INFORMANT: Hugh Eagleton ADDRESS: 7702 Radnor Road Bethesda, Md. 20817

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Leukemia — 10 years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Anemia

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July 1980 to Feb 9 1989, that (I) (we) last saw the deceased alive on Feb 7 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas Havell DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Thomas Havell

22e. ADDRESS: 4201 Cathedral Ave.,N.W. Washington,D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2-10-89

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE

24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisconsin Ave.,N.W. Washington,D.C.20016

25a. DATE REC'D. BY REGISTRAR: FEB 10'89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 25

DHMH - 16 50M 1/81 (VRA 15, 4)

024068 FEB 23 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005432 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jacob	MIDDLE: N.	LAST: EISEN	2a. DATE OF DEATH MONTH DAY YEAR: 2-21-89	2b. HOUR: 7:46 AM
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 21 23	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: TAKoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Statistician (Ret.)	12b. KIND OF BUSINESS OR INDUSTRY: I.R.S.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Potomac	YES [ ] NO [ ]	8129 Paisley Place (20854)

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Solomon / / Eisen	Yetta / / Rosenthal

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
Yes	WWII	083-18-4724	Selma Eisen; Wife; 8129 Paisley Place; Potomac Maryland 20854	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiogenic Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hr

DUE TO, OR AS A CONSEQUENCE OF (b): Severe Coronary Artery Disease — Yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug 88 to Feb 21 19 89, that (I) (we) last saw the deceased alive on Feb 21 19 89, and that to my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: Alan I. Kermaier, MD — DEGREE — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN I. KERMAIER, MD — 22e. ADDRESS: 10313 GEORGIA AVE. SS. 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/23/89	Judean Memorial Gardens	Olney; Montgomery; Maryland

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

24a. DATE REC'D BY REGISTRAR: FEB 23 1989 — REGISTRAR'S SIGNATURE

DHMH - 1650M 1/81 (VRA 15, 4)

BP_____

024160 FEB 29 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005433

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): (AKA FRANK) TIMOTHY FRANCIS ERTTER
2a. DATE OF DEATH: MONTH 2 DAY 5 YEAR 89
2b. HOUR: 1:42 P.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH 6 DAY 6 YEAR 1905
6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED
12b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVERNMENT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 9209 Scott Drive 20852

14. FATHER'S NAME: JOHN FERDINAND ERTTER
15. MOTHER'S MAIDEN NAME: MARY ELLEN CRAIN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
16b. (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 219 12 2570
17. INFORMANT: GLADYS ERTTER (WIFE) ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Right Frontoparietal cerebral infarction — days
DUE TO, OR AS A CONSEQUENCE OF (c): Atherosclerotic cerebral vascular disease — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Chronic cardiomyopathy, Permanent pacemaker for sick sinus node syndrome, Cardiac arrhythmias

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 89 to 2/5 19 89, that (I) (we) last saw the deceased alive on 2/4 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Byrl D. Johnson — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/5/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): BYRL D. JOHNSON
22e. ADDRESS: 911 N. Russell Ave. Gaithersburg, MD. 20879

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/9/89
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park
23d. LOCATION CITY OR TOWN: Rockville COUNTY: Maryland STATE:
24. FUNERAL DIRECTOR NAME AND ADDRESS: Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852
25a. DATE REC'D. BY REGISTRAR: FEB 08 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 18

DHMH - 16 50M 1/81 (VRA 15, 4)

024709 MAR-6 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05434
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
ELLA	M.	EVANS	2	14	89	4:45AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
female	white	May 1, 1904	84 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
PA	USA		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	National Lutheran Home for the Aged	homemaker	home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Montgomery	Rockville	YES ☒ NO ☐	9701 Veirs Drive 20850

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John E.		Alger	Luvina		Berflinger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		234-01-7930	Edith Lyon, Martinsburg, WV 25401

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	BRAIN METASTASES	3 days
DUE TO, OR AS A CONSEQUENCE OF (b)	MALIGNANT MELANOMA	6 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (~~Was hospital~~) attended the deceased from Jan 1, 19 88, to Feb 14, 19 89, that (I) (~~saw~~) last saw the deceased alive on Feb 13, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Thomas E. Dooley MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb 14, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Thomas E. Dooley, MD	9701 Veirs Drive Rockville, MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/17/89	Rosedale Cemetery	Martinsburg,	Berkeley,	WV

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rosedale F.H.	MARTINSBURG WV.	MAR 03 1989	Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

025288 MAR 14 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05435 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 28

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	William	Joseph	Evans	2a. DATE OF DEATH — MONTH / DAY / YEAR	2 / 14 / 89
2b. HOUR	8 A M				
3. SEX	M	4. RACE	W	5. DATE OF BIRTH — MONTH / DAY / YEAR	4 / 2 / 10
6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	New York	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery Co. MD.				
10. CITY OR TOWN OF DEATH	Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Shady Grove Adventist Hosp. DOA	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Physician
12b. KIND OF BUSINESS OR INDUSTRY	Health Care				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Montgomery	Gaithersburg	YES ☒ NO ☐	9701 Fields Rd #1803 20878

14. FATHER'S NAME — FIRST / MIDDLE / LAST	William	J.	Evans	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Margaret		O'Brian

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		215-44-3074	Therese Evans	9701 Fields Rd Gaithersburg, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Apparent Myocardial Infarction.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema

DUE TO, OR AS A CONSEQUENCE OF (c) CHF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: IDDM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-9, 19 88, to 2-14, 19 89, that (I) (we) last saw the deceased alive on 1-29, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. Information was from Dr. Bell at Shady Grove Adventist Hospital

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
LL Prokop DO			2-14-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
LL Prokop DO	102 Irving St, NW Washington, DC 20010

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	17 FEB 89	Mt. Olivet Cem.	Washington, DC

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DeVol Funeral Home 10 E Deer Park Dr. Gaithersburg, MD	FEB 16 '89	Julia Davidson-Randall

0 2 5 3 6 8 MAR 16 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005436 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Randolph	MIDDLE: H.	LAST: Fairfax	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH: 2	DAY: 17	YEAR: 1989	2b. HOUR
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH: Nov.	DAY: 12,	YEAR: 1961	6. AGE (IN YEARS LAST BIRTHDAY): 27 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
2c. DATE PRONOUNCED DEAD MONTH: 2	DAY: 17	YEAR: 1989	2d. HOUR: 11:20 a M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD			
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Warehouseman	12b. KIND OF BUSINESS OR INDUSTRY: Sears			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Montg.	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 17817 Washington Grove Lane	20877	
14. FATHER'S NAME FIRST / MIDDLE / LAST: Calvin Copeland	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Geraline Cross					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 212-80-1600	17. INFORMANT: Geraline Fairfax (Mother)	ADDRESS: 16112 Frederick Road Rockville, MD 20855			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hanging
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH: 10 xx 2 DAY: 17 YEAR: 19 88	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject hanged self
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): jail cell	21f. LOCATION STREET: Seven Locks Rd, CITY OR TOWN: Rockville, COUNTY: Mont, STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Golle Jr M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2/17/89

EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr, M.D. ADDRESS: 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-22-89	23c. NAME OF CEMETERY OR CREMATORY: Lincoln Park Cem.	23d. LOCATION CITY OR TOWN: Rockville, COUNTY: Montg, STATE: MD	
24. FUNERAL DIRECTOR NAME: George R. Snowden	ADDRESS: Rockville, MD 20850	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

07/B4 25M BP

DHMH - 17 (VR A15 ME (5))

023455 FEB 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05437
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ESTHER — MIDDLE: — LAST: FANAROFF
2a. DATE OF DEATH — MONTH: 02 — DAY: 16 — YEAR: 89
2b. HOUR: 7:20 A.M.
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH — MONTH: Nov. — DAY: 29 — YEAR: 1902
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS / HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 15115 Interlachen Drive, #515 (20906)

14. FATHER'S NAME — FIRST: Hyman — MIDDLE: — LAST: Sidenberg
15. MOTHER'S MAIDEN NAME — FIRST: Ida — MIDDLE: — LAST: (Unknown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): ---------
16b. SOCIAL SECURITY NO.: 579-34-5538
17. INFORMANT: Rhoda Kline; Daughter; 15115 Interlachen Drive, #515; Silver Spring, Md. 20906

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): ASPIRATION PNEUMONITIS
DUE TO, OR AS A CONSEQUENCE OF (c): MULTI-INFARCT DEMENTIA

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/4/88 to 2/16/89, that (I) (we) last saw the deceased alive on 2/16/89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Coroner) did not view the body after death.
22b. SIGNATURE: A.D. Patel — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/16/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. D. PATEL
22e. ADDRESS: 6121 MONTROSE RD ROCKVILLE MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/17/89
23c. NAME OF CEMETERY OR CREMATORY: D.C. Lodge Cemetery
23d. LOCATION — CITY OR TOWN — COUNTY — STATE: S.E. Washington, D.C.
24. FUNERAL DIRECTOR NAME: DANZANSKY-GODLBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852
25a. DATE REC'D. BY REGISTRAR: FEB 21 1989
25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, then 18 should show any injury, or other traumatic event, the medical examiner must be notified promptly.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

(025308 MAR 1 4 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05438 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: S	LAST: Farmer	2a. DATE OF DEATH MONTH DAY YEAR: 2-12-89		2b. HOUR: 1140 PM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: September 9, 1925	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 9619 Singleton Drive 20817	
14. FATHER'S NAME FIRST: Thomas	MIDDLE: J.	LAST: Sullivan	15. MOTHER'S MAIDEN NAME FIRST: Alice	MIDDLE:	LAST: Dahl
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579-28-5408	17. INFORMANT ADDRESS: Murray W. Farmer, Husband, Same as #13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	hypotension	one 24 o
DUE TO, OR AS A CONSEQUENCE OF (b)	Sepsis	7 days
DUE TO, OR AS A CONSEQUENCE OF (c)	adult respiratory distress syndrome	7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: lung cancer, chronic obstructive lung disease

19a. DATE OF OPERATION: 3 Feb 89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: lung cancer	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2 Jan 89 to 12 Feb 89, that (I) (we) last saw the deceased alive on 12 Feb 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 13 Feb 89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Alan R Pollack, MD	22e. ADDRESS: 809 Viers Mill Rd Rockville Md 20851		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 15, 1989	23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington, Virginia	
24. FUNERAL DIRECTOR (NAME AND ADDRESS): Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814			25a. DATE REC'D. BY REGISTRAR: FEB 14'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

024100 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05439
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby	MIDDLE: —	LAST: Felder	"A"	2a. DATE OF DEATH MONTH 1 DAY 31 YEAR 89	2b. HOUR 8:30 PM
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH 1 DAY 31 YEAR 89		6. AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS 4 MIN. 20
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Montgomery	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A	12b. KIND OF BUSINESS OR INDUSTRY: N/A
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN: Wash. D.C.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: #204 3539 E. Capitol St. S.E.	20019
14. FATHER'S NAME FIRST: Ronell	MIDDLE: Eldridge	LAST: Buchanan	15. MOTHER'S MAIDEN NAME FIRST: Shabrena	MIDDLE: Arneice	LAST: Felder
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ------	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Shabrena A. Felder (mother)	ADDRESS: same as 13e	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Extreme immaturity
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): N/A

19a. DATE OF OPERATION: N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/31 19 89 to 1/31 19 89, that (I) (we) last saw the deceased alive on 1/31 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Katherine C White MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): KATHERINE C. WHITE — 22e. ADDRESS: HOLY CROSS HOSPITAL 1500 FOREST GLEN RD SILVER SPRING MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/7/89	23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory	23d. LOCATION CITY OR TOWN: Alexandria, COUNTY / STATE: Virginia

24. FUNERAL DIRECTOR NAME AND ADDRESS: Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: FEB 08 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 1

DHMH - 16 SOM 1/81 (VRA 15, 4)

024099 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05440
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby	MIDDLE: -	LAST: Felder "B"	2a. DATE OF DEATH MONTH: 1 DAY: 31 YEAR: 89	2b. HOUR: 8:30 P M	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH: 1 DAY: 31 YEAR: 89	6. AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS HOURS: 4 MIN: 17
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Montgomery	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A	12b. KIND OF BUSINESS OR INDUSTRY: N/A		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN: Wash. D.C.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS #204: 3539 E. Capitol ST. S.E. 20019	
14. FATHER'S NAME FIRST: Ronell	MIDDLE: Eldridge	LAST: Buchanan	15. MOTHER'S MAIDEN NAME FIRST: Shabrena	MIDDLE: Arneice	LAST: Felder
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -------	16b. SOCIAL SECURITY NO.: None	17. INFORMANT ADDRESS: Shabrena A. Felder (mother) same as 13e		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Extreme immaturity
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/31, 19 89, to 1/31, 19 89, that (I) (we) last saw the deceased alive on 1/31, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: Katherine C White MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): KATHERINE C. WHITE MD — 22e. ADDRESS: HOLY CROSS HOSPITAL 1500 FOREST GLEN RD SILVER SPRING MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/7/89	23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory	23d. LOCATION CITY OR TOWN: Alexandria, COUNTY: Virginia, STATE
24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home, Inc. ADDRESS: 1331 Rockville Pike, Rockville, Md. 20852	25a. DATE REC'D. BY REGISTRAR: FEB 08 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Hopkins	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 1

DHMH - 1650M 1/81 (VRA 15, 4)

024303 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05441
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Bernice	Middle: M	Last: Fellman	2a. DATE OF DEATH Month/Day/Year: 2/24/89		2b. HOUR: 6:12 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month/Day/Year: July 17, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Norfolk, Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES [X] NO [ ]	2404 Harmon Road (20902)

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
Dave / Miller	Annie / Levine	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	-----	226-14-6655	Harry Fellman; Husband; 2404 Harmon Road; S. Spg	Md. 20902

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hepatic failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO, OR AS A CONSEQUENCE OF

(b) Cirrhosis — ~1 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/24/89	Ascites, Cirrhosis	YES [X] NO [ ]	YES [ ] NO [X]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M./P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/23/89, 19__, to 2/24, 19 89, that (I) (we) last saw the deceased alive on 2/23, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/25/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Howard Goldberg	12013 Vears Mill Rd Wheaton MD 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/27/89	King David Mem. Garden	Falls Church; Fairfax; Va.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS	1170 Rockville Pike; Rockville, Md. 20852	MAR 1 - 1989	Gina Murdson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

21827 FEB-6 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 005442

1. DECEASED NAME (TYPE OR PRINT): FIRST Fannie MIDDLE B LAST Fenichel

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH Feb DAY 2 YEAR 19 89

2b. HOUR 1607 M

3. SEX: F

4. RACE: W

5. DATE OF BIRTH: MONTH March DAY 16 YEAR 1879

6. AGE (IN YEARS LAST BIRTHDAY): 109 YRS.

IF UNDER 1 YR. MONTHS / DAYS

IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 2 YEAR 19 89

2d. HOUR 1807 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Sil. Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 8101 Eastern Avenue, #213 (20910)

14. FATHER'S NAME: FIRST Aaron MIDDLE LAST Bressler

15. MOTHER'S MAIDEN NAME: FIRST Rose MIDDLE LAST Bauman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 577-03-7116

17. INFORMANT: Benjamin Fenichel; Husband; 8101 Eastern Ave #213, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Dis.

DUE TO, OR AS A CONSEQUENCE OF

(b): Chronic Myocardial Dis.

DUE TO, OR AS A CONSEQUENCE OF

(c): ----------

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER DATE SIGNED: Feb. 2 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS: Seminary Road; Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/3/89

23c. NAME OF CEMETERY OR CREMATORY: D.C. Lodge Cemetery

23d. LOCATION CITY OR TOWN Washington COUNTY D.C. STATE

24. FUNERAL DIRECTOR NAME: Danzansky-Goldberg Memorial Chapels ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: FEB 3 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL (ITEMS 2a, 2b, 2c, 2d). SEE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ONLY WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024065 FEB 23 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05443
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 24 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
MORRIS	C.	FINKEL	February 20, 1989	11:15	a.m.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	Caucasian	June 9, 1906	82 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Poland	U.S.A.		Montgomery County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Meridian Nursing & Rehab. Center	Assist.Supt.of Schools	Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES ☐ NO ☐	3476 Chiswick Court (20906)

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Emanuel		Finkel	Taubele		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	-----	100-32-3064	Jan Finkel;Wife	3476 Chiswick Court;Silver Spring, Md. 20906

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	24 Hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Generalized Debility, Renal, Liver Failure	2 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Parkinsons with Dementia	2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypothyroid, Diabetes, ASHD, ASPVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from Dec. 19 88, to Feb. 20 19 89, that (I) (~~we~~) last saw the deceased alive on Feb. 15 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Oliver Lawless	MD	☐ ☑ ☐	2/20/1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
OLIVER J. LAWLESS, M.D.	3801 International Drive, #201; Silver Spring, Md. 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/22/89	New Montefiore Cemetery	Pinelawn, L.I., New York

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	FEB 23 1989	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

025183 MAR 14 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05444
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Benjamin	MIDDLE: David	LAST: Gaither	2a. DATE OF DEATH MONTH DAY YEAR: 1 24 89	2b. HOUR: 10:25 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 01 01 1912	6. AGE (IN YEARS LAST BIRTHDAY): 77 years YRS.	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Brunswick, MD	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Loc. Eng.	12b. KIND OF BUSINESS OR INDUSTRY: B&O RR	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Springs	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 10103 Grant Avenue 20912
14. FATHER'S NAME FIRST: Paul	MIDDLE: William	LAST: Gaither	15. MOTHER'S MAIDEN NAME FIRST: Mame	MIDDLE: Ruth LAST: Barger
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 408-09-9821	17. INFORMANT: Anna L. Gaither	ADDRESS: 10103 Grant Avenue Silver Springs, Md 20910

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): HYPERKALEMIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 HRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ACUTE/CHRONIC RENAL FAILURE — 4 DAYS

DUE TO, OR AS A CONSEQUENCE OF (c): MALNUTRITION — 2 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): PULMONARY INFILTRATES, STROKE, PLEURAL EFFUSIONS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from ____ 19 75 to 1/24 19 89, that (I) (~~we~~) last saw the deceased alive on 1/24 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Daniel Rosenblum	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 1/24/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANIEL ROSENBLUM	22e. ADDRESS: 10400 CONNECTICUT AV KENSINGTON, MD 20895		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/28/1989	23c. NAME OF CEMETERY OR CREMATORY: Park Heights Cemetery	23d. LOCATION CITY OR TOWN: Brunswick	COUNTY: Frederick STATE: MD
24. FUNERAL DIRECTOR NAME: John A. Williams Funeral Home	ADDRESS: 100 Petersville Rd Brunswick, MD 21716	25a. DATE REC'D. BY REGISTRAR: FEB 01 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

#18,22a,FilmG650 4/11/89 KM

023398 FEB 2 '89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05445

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "DEATH PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2. DECEASED NAME (TYPE OR PRINT) FIRST: Carlos	MIDDLE	LAST: Garcia-Tunon	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐: MONTH 2 DAY 8 YEAR 89	2b. HOUR			
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Oct 18,1944	6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD: 2-8-89	2d. HOUR: 8:00A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Cuba	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED XX ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.				
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 7502 Glennon Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mortgage Banker	12b. KIND OF BUSINESS OR INDUSTRY: Banking				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Potomac	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13. STREET ADDRESS: 7502 Glennon Dr.	20854 -20817		
14. FATHER'S NAME FIRST: Alberto	MIDDLE	LAST: Garcia-Tunon	15. MOTHER'S MAIDEN NAME FIRST: Cristina	MIDDLE	LAST: Gelats		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 578-58-4341	17. INFORMANT ADDRESS: Gisela Garcia-Tunon Same as item #13				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrhythmia with cardiomegaly
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XXX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XXX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-9-89

VC EXAMINER'S NAME (TYPE OR PRINT) James Kaplan,M.D. ADDRESS 111 Penn street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-10-89	Gate of Heaven Cem.	Silver Spring,Montgomery,MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisconsin Av. NW, Washington, DC 20016

25a. DATE REC'D. BY REGISTRAR: FEB 10'89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025277 MAR 1 '89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05446
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First Allen Middle Howard Last Gardner — Allen H. Gardner
2a. DATE OF DEATH: Month 2 Day 16 Year 89
2b. HOUR: 9:45 AM
3. SEX: MALE
4. RACE: Caucasian
5. DATE OF BIRTH: Month Dec Day 4, Year 1898
6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Attorney
12b. KIND OF BUSINESS OR INDUSTRY: Law Firm

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 1515 Dale Drive 20910

14. FATHER'S NAME: First Truman Middle Grant Last Gardner
15. MOTHER'S MAIDEN NAME: First Viola Middle — Last Allen
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 220-44-2345A
17. INFORMANT: Allen S. Gardner
ADDRESS: 7845 Willowbrook Rd. Fairfax Station, VA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): aspiration pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Alzheimer's disease

19a. DATE OF OPERATION: N/A
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): N/A
21b. TIME OF INJURY: HOUR A.M. P.M. N/A MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): N/A
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ N/A
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): N/A
21f. LOCATION STREET: N/A CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/ / 19 63 to 2/16 19 89, that (I) (we) last saw the deceased alive on 2/16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Kathryn S. Kirwin DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/16/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): KATHRYN S. KIRWIN
22e. ADDRESS #606 10400 Connecticut Ave. Kensington, MD 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb 22, 1989
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION CITY OR TOWN: Suitland COUNTY STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisconsin Av. NW, Washington, DC 20016
25a. DATE REC'D. BY REGISTRAR: FEB 17 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 8

DHMH - 1650M 1/81 (VRA 15, 4)

023178 FEB 17 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 9 0 5 4 4 7 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SHARON	MIDDLE: H.	LAST: GARFINKLE	2a. DATE OF DEATH MONTH DAY YEAR: 2-10-89	2b. HOUR: 1115 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 12-15-44	6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary-Medical	12b. KIND OF BUSINESS OR INDUSTRY: Dental Office		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES ☒ NO ☐	14410 Parkvale Drive (20853)

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Myron		Garfinkle	Minnie		Alenstein

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	----------	219-42-2920	Ricky Bellman; Brother-in-Law	2 McCormick Ct. Rockville, Md. 20850

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Mult Organ Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): penetrated peptic ulcer — 4 days

DUE TO, OR AS A CONSEQUENCE OF (c): Pancreatic leak — 4days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Protein - calorie malnutrition

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/18/89	gastric outlet obstruction	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/16, 19 89, to 2/10, 19 89, that (I) (we) last saw the deceased alive on 2/10, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CURED, D KOVIN — 22e. ADDRESS: 1011 N. Capitol St

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/13/89	King David Mem. Garden	Falls Church; Fairfax; Va.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	FEB 15 1989	[signature] Deputy Registrar

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

025309 MAR 14 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 105443
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP 25+1

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JAMES DANIEL GILLMORE				FEBRUARY 11 1989	11:10 A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS: HOURS, MIN.
MALE	CAUCASIAN	JANUARY 23 1915	74 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
WASHINGTON	UNITED STATES		MONTGOMERY COUNTY, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	NAVAL HOSPITAL		RETIRED	U.S.NAVY DEPT.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	POTOMAC	YES ☐ NO ☒	11400 GAINSBOROUGH ROAD 20854

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JOHN GILLMORE	HARRIET WADE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	1940-1961	535-03-6973	LOUISE G. GILLMORE, 11400 GAINSBOROUGH ROAD, POTOMAC, MD 20854

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b) ASPIRATION PNEUMONITIS/PNEUMONIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 19, 1988 to FEBRUARY 11, 1989, that (I) (we) last saw the deceased alive on FEBRUARY 11 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
J. Sherry	M.D.	☐ / ☐ / ☒	2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. SHERRY, LT, MC, USNR	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	FEB. 16, 1989	PARKLAWN MEMORIAL PARK	ROCKVILLE, MARYLAND

24. FUNERAL DIRECTOR NAME AND ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY FUNERAL HOME ROCKVILLE, INC., 300 WEST MONTGOMERY AVENUE, ROCKVILLE, MARYLAND 20850	FEB 14 '89	Julia Davidson-Randall

024143 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05449 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been [illegible] attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then [illegible] carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to [illegible], cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any [illegible] any other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Michael	Middle: F.	Last: Godfrey	2a. DATE OF DEATH Month Day Year: February 1, 1989		2b. HOUR: 10 40 PM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH Month Day Year: 7 29 12	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Brooke Grove Nsg Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Civil Engineer	12b. KIND OF BUSINESS OR INDUSTRY: FHA	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY	13c. CITY OR TOWN: Washington, DC	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 3032 Oliver St. N.W.	Zip: 20015
14. FATHER'S NAME First: Michael	Middle: F	Last: Godfrey	15. MOTHER'S MAIDEN NAME First: Elizabeth	Middle:	Last: McClintock
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 579-09-2043	17. INFORMANT: Margaret A Godfrey	ADDRESS: 3032 Oliver St NW Wash. D.C.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (a)	SEPSIS	4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	ASPIRATION PNEUMONIA	7 days
DUE TO, OR AS A CONSEQUENCE OF (c)	ALZHEIMER'S DEMENTIA	1 YEAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): JAUNDICE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4-22, 19 88, to FEB 1, 19 89, that (I) (we) last saw the deceased alive on JAN 15, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Elvin Adams, M.D.	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED: Feb 1 1989	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ELVIN ADAMS, M.D.	22e. ADDRESS: 18430 Brookgrove RD, OLNEY MARYLAND 20832		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 4, 1989	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN: Silver Spring	COUNTY / STATE: Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 641

DHMH-16 25M (VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05450
REG. NO.

023655 FEB 23 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ME Related #L

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOE	MIDDLE	LAST: GOLDSTEIN	2a. DATE OF DEATH MONTH DAY YEAR: February 13, 1989		2b. HOUR: 3:50 P M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: June 17, 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Business Owner	12b. KIND OF BUSINESS OR INDUSTRY: Alteration Cleaning		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 6121 Montrose Rd (20852)	
14. FATHER'S NAME FIRST: Eliyah	MIDDLE: Wolf	LAST: Goldstein	15. MOTHER'S MAIDEN NAME FIRST: Rifka	MIDDLE	LAST: (UNKNOWN)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): --------	16b. SOCIAL SECURITY NO.: 087-26-4507	17. INFORMANT: Grandson	ADDRESS: Maryland 20850 David Hurwitz:10 Plum Grove Way:Gaithersburg	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary arrest.	sudden.
DUE TO, OR AS A CONSEQUENCE OF (b)	Septic Shock.	sudden.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-13, 19 89, to 2-13, 19 89, that (I) (we) last saw the deceased alive on 2-13, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Loreto S. Albiol DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LORETO S. ALBIOL, MD 22e. ADDRESS: 6121 MONTROSE. Rd.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/16/89	23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Gdn.	23d. LOCATION CITY OR TOWN: Falls Church	COUNTY / STATE: Virginia
24. FUNERAL DIRECTOR NAME AND ADDRESS: Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike: Rockville, Md 20852		25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

022442 FEB 1 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 05451
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Francisco	J.	Gonzalez	February 3, 1989	12:20 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	white	June 19, 1916	72 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Cuba	United States		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Grosvenor Health Care Center	Clerk	Insurance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Gaithersburg	YES ☐ NO ☐	#314 101 Odend'hal Avenue / 20877

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Francisco	Gonzalez	Garcia	Aida	Rodriguez	Dorta

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		263-23-2937	Edna I. Gonzalez, Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accidents, Multiple

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct -1, 19 88, to February 3, 19 89, that (I) (we) last saw the deceased alive on 1-30, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John F. Tauber MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb. 3, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John F. Tauber, M. D.	8218 Wisconsin Avenue, #414 Bethesda, MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-3-89	Suburban Crematory	Silver Spring, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910	FEB 6 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, disinterment, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

023454 FEB 22 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005452
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: IRA	MIDDLE: H.	LAST: GOODMAN	2a. DATE OF DEATH MONTH DAY YEAR: 2-15-89	2b. HOUR: 2:40 PM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: May 29, 1926	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balt., Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY Co. MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Business Owner	12b. KIND OF BUSINESS OR INDUSTRY: Auto Sales	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	13121 Fox Hall Road (20902)

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Sol / / Goodman	Evelyn / / Pear	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 577-32-9025	17. INFORMANT / ADDRESS: Craig Goodman; Son; 8021 Cypress Grove Lane; MD Cabin John,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: INSTANT.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CARDIOMYOPATHY — YEARS

DUE TO, OR AS A CONSEQUENCE OF (c): CORONARY ARTERY DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPERTENSION, RENAL FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 89 to 2/15 19 89, that (I) (we) last saw the deceased alive on 2/15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
D.R. Rosing MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/15/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): D.R. ROSING, M.D.	22e. ADDRESS: ~~11125 Rockville Pike~~ 4410 ROCKLEDGE DR. SUITE 200, BETHESDA, MD 20817	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/17/89	Judean Memorial Gardens;	Olney; Montgomery; Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	FEB 21 1989	Jane Harrison-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024091 FEB 28 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05453
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST John MIDDLE J. LAST Gorman
John, J. Gorman, Jr.

2a. DATE OF DEATH: MONTH DAY YEAR: 2-7-89
2b. HOUR: 7:00 PM

3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH DAY YEAR: Aug 7, 1918
6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Banker
12b. KIND OF BUSINESS OR INDUSTRY: Banking

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Kensington
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 4209 McCain Ct. 20895

14. FATHER'S NAME: FIRST John MIDDLE J. LAST Gorman
15. MOTHER'S MAIDEN NAME: FIRST Ann MIDDLE LAST Wagner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 579-05-1432A
17. INFORMANT ADDRESS: Louise S. Gorman Same as item # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Ventricular fibrillation
DUE TO, OR AS A CONSEQUENCE OF (c): atherosclerotic cardiovascular disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes, hypertension, old cerebral infarction

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from 2/7 19 89 to 2/7 19 89, that I (we) last saw the deceased alive on 2/7 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H Robert Birschbach DEGREE: MD
ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): H. Robert Birschbach, M.D.
22e. ADDRESS: 6320 Democracy Blvd. Beth., MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-10-89
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Mem. Park
23d. LOCATION: CITY OR TOWN Rockville, COUNTY Montgomery, STATE MD

24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc.
ADDRESS: 5130 Wisconsin Av. NW, Washington, DC 20016
25a. DATE REC'D. BY REGISTRAR: FEB 10 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

023328 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 05454
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Richard MIDDLE: Scott LAST: Gouff			2a. DATE OF DEATH MONTH DAY YEAR: 2/4/89	2b. HOUR: 10:45 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 3, 1947	6. AGE (IN YEARS LAST BIRTHDAY): 42 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland,	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Metro Bus	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES [X] NO [ ]	2601 Briggs Chaney Rd. 20904

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Kenneth / E. / Gouff	Betty / J. / Comer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	Viet Nam	212-50-8006	Theresa Gouff-wife - (same as above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE ANTERIOR MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/3, 19 89, to 2/4, 19 89, that (I) (we) last saw the deceased alive on ____, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Alpana Goswami	MD	[X] / [ ] / [ ]	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ALPANA GOSWAMI MD	8401 Colesville Road, Silver Spring MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-8-1989	Metropolitan Crematory	Alexandria / Virginia

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines-Rinaldi Funeral Home	11900 N.H. Ave., Silver Spring, Md.	FEB 07'89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

024449 MAR -12 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005455
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please have coroner complete and sign papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 31 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Russell	MIDDLE: W	LAST: Gray	2a. DATE OF DEATH MONTH DAY YEAR: 2 22 89	2b. HOUR: 1150 A M
3. SEX: Male.	4. RACE: White.	5. DATE OF BIRTH MONTH DAY YEAR: Mar. 19, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Potomac, Md.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Rockville, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Funeral Director Retired.	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montg.	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ X NO ☐	13e. STREET ADDRESS / ZIP CODE: 718 Chesapeak Ave. 20910
14. FATHER'S NAME FIRST: Richard	MIDDLE: H.	LAST: Gray.	15. MOTHER'S MAIDEN NAME FIRST: Not	MIDDLE: Available. LAST:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No. (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-03-3328	17. INFORMANT: Hilda S. Gray.	ADDRESS: 13 (e)	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9289
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): NON-HODGKIN'S LYMPHOMA
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: CONGESTIVE HEART FAILURE, PNEUMONIA & SMALL BOWEL

19a. DATE OF OPERATION: 2/18/89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Intestinal Hemorrhage.	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/19/89 19 89, to 2/22 19 89, that (I) (we) last saw the deceased alive on 2/20 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Bernard Fogel M.D. — 22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial.	23b. DATE: Feb. 27,	23c. NAME OF CEMETERY OR CREMATORY: 1989 Parklawn.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Rockville, Montg. Md.	
24. FUNERAL DIRECTOR: Arthur Walters	ADDRESS: Takoma Funeral Home Inc. 254 Carroll St. N. W. D. C.	25a. DATE REC'D. BY REGISTRAR: FEB 27 1989	25b. REGISTRAR'S SIGNATURE: Julia Saunders-Randall	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

023375 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005456 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: GEORGE	Middle: A.	Last: GRAY Jr., MD	2a. DATE OF DEATH Month Day Year: 2 - 1 - 89
2b. HOUR: 10 35 AM			
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH Month Day Year: October 23, 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.
If under 1 year: Months / Days	If under 24 hrs: Hours / Min.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Physician	12b. KIND OF BUSINESS OR INDUSTRY: Medicine

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES [ ] NO [X]	7700 Marbury Road/20817

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George	A.	Gray, Sr.	Edith		Stearns

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	219-28-3549	Barbara S. Gray	same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		Approximate interval between onset and death
IMMEDIATE CAUSE (a)	CARDIOGENIC SHOCK	10 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)	ACUTE INFEROPOSTERIOR INFARCTION	12 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ACUTE RENAL FAILURE AND RIGHT FEMORAL ARTERY EMBOLISM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from JAN 20, 19 89, to FEB 1, 19 89, that (I) (we) last saw the deceased alive on JAN 31, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Roger Stevenson MD	MD	[ ] [X] [ ]	2/1/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Roger Stevenson, Jr. MD	6410 Rockledge Dr. Bethesda, MD 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 3, 1989	Fort Lincoln Cemetery	Brentwood / Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814	FEB 02 '89	Julia Davidson-Randall

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

025305 MAR 14 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05457
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Marvin H. Greene			2a. DATE OF DEATH MONTH DAY YEAR	Febuary 12, 1989
				2b. HOUR	1040PM
3. SEX	MALE	4. RACE	CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR	12 11 19
6. AGE (IN YEARS LAST BIRTHDAY)	69 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	SOUTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery County MD.				
10. CITY OR TOWN OF DEATH	Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	WINDSHIELD REPAIR
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	ROCKVILLE	YES ☐ NO ☐	11103 FEDERAL COURT 20853

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
JAMES / / GREENE	CORA / B. / BURNS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		247-24-6926	THELMA L. GREENE/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary collapse	4 HR.
DUE TO, OR AS A CONSEQUENCE OF (b)	pericardial Tamponade	4 HR.
DUE TO, OR AS A CONSEQUENCE OF (c)	Lung Carcinoma	2 YR.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb. 12, 19 89, to Feb. 12, 19 89, that (I) (we) last saw the deceased alive on Feb. 12, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
Frank J. Mayo	MD		2-12-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Frank J. MAYO, MD	16220 Frederick Rd. Gaithersburg MD 20877

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 15, 1989	PARKLAWN CEMETERY	ROCKVILLE MONTGOMERY MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 15 '89	Julia Davidson-Randall

BP 20

DHMH - 1650M 1/81 (VRA 15, 4)

025349 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05453
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Rose		Greenbaum	Feb. 19, 1989	8:00 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	White	03 13 1897	91 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	USA		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Chevy Chase	4701 Willard Ave. #1131	Appraiser	P.J. Curry Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Mont.	ChevyChase	YES ☒ NO ☐	4701 Willard Ave., #1131

2085

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel		Greenbaum	Anna		Gerst

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		054-09-9382	Carol Engel; 2412 Tunlaw Rd.	Washington, D.C. 20007

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
Carcinoma of the colon

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-17 19 86 to 2-19 19 89, that (I) (we) last saw the deceased alive on 2-17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James H Brodsky	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-20-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James H. Brodsky M.D.	4701 Willard Ave, #224; Chevy Chase MD, 20815

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	02-21-89	Mt. Comfort Crem.	Alexandria VA

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Jos. Gawler's Sons, Inc.	5130 WI Ave. NW Wash., DC 20016	FEB 22 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or give

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 4

DHMH - 16 50M 1/81
(VRA 15, 4)

022952 FEB 16 89

1. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05459
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Joseph — MIDDLE: — LAST: Greenman
2a. DATE OF DEATH (MONTH, DAY, YEAR): 2/8/89
2b. HOUR: 8:00 PM
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH (MONTH, DAY, YEAR): 12 28 01
6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. — # UNDER 1 YEAR: MONTHS, DAYS — # UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): England
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Silver Spring MD
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Plumber (Ret.)
12b. KIND OF BUSINESS OR INDUSTRY: U.S.Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 9039 Sligo Creek Parkway #203 (20901)

14. FATHER'S NAME — FIRST: Moses — MIDDLE: — LAST: Greenman
15. MOTHER'S MAIDEN NAME — FIRST: Regina — MIDDLE: — LAST: Kroesen
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): ---------
16b. SOCIAL SECURITY NO.: 578-18-3774
17. INFORMANT — ADDRESS: Eleanor Ostrinsky; Daughter; 10603 Cavalier Dr. Silver Spring, Md. 20901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): End Stage Renal Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO, OR AS A CONSEQUENCE OF (b): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJUBY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 21 Jan 19 89 to 8 Feb 19 89, that (I) (we) last saw the deceased alive on 8 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT):
22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/12/89
23c. NAME OF CEMETERY OR CREMATORY: King David Memorial Garden
23d. LOCATION — CITY OR TOWN: Falls Church; COUNTY: Fairfax; STATE: Va.

24. FUNERAL DIRECTOR — NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852
25a. DATE REC'D. BY REGISTRAR: FEB 14 1989
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

023313 FEB 21

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005460

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: KAREN	MIDDLE: L.	LAST: Greenspan	2a. DATE OF DEATH MONTH DAY YEAR: 2-13-89	2b. HOUR: 2:30 P.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 3 05 60	6. AGE (IN YEARS LAST BIRTHDAY): 28 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON D. C.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET AND NUMBER): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NONE	12b. KIND OF BUSINESS OR INDUSTRY: NONE	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES XX NO ☐	12509 SUMMERWOOD DRIVE 20904

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
FRANK	R.	GREENSPAN	LOIS	R.	ROSENBERG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT'S NAME AND ADDRESS
NO		213-78-9377	FRANK R. and LOIS R. GREENSPAN, 12509 SUMMERWOOD DRIVE, SILVER SPRING, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Exsanguination	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Ruptured Gastrohepatic Varices	1 month
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 1-14 19 89, to 2-13 19 89, that (I) (we) last saw the deceased alive on 2-12- 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Frederick A Bar	M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
FREDERICK G. BAR, M.D.	5454 WISCONSIN AVENUE, SUITE 835 CHEVY CHASE, MD 20815

23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/15/1989	MOUNT LEBANON CEMETERY	ADELPHI, PR. GEO., MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.	FEB 16 1989	Julia Davidson-Randall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

025295 MAR 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR — REG. NO. 89 005461

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST Norman	MIDDLE Charles	LAST Grubby	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐	MONTH 2	DAY 14	YEAR 19 89	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Apr. DAY 6 YEAR 1925	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH 2 DAY 14 YEAR 19 89		2d. HOUR 7:55 P. M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13305 Midway Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Video Controller		12b. KIND OF BUSINESS OR INDUSTRY WRAMC		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS 13305 Midway Avenue 20851				
14. FATHER'S NAME FIRST Thomas	MIDDLE	LAST Grubby	15. MOTHER'S MAIDEN NAME FIRST Dora	MIDDLE	LAST Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	(IF YES, GIVE WAR OR DATES) WWII & Korea	16b. SOCIAL SECURITY NO. 146-12-1255	17. INFORMANT Ruth B. Grubby, Wife, Same as #13	ADDRESS				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) carcinoma of the lung.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
None		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2/15/89

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road, Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 17, 1989	Arlington National Cem.	Arlington, Virginia

24. FUNERAL DIRECTOR AND ADDRESS Robert A. Pumphrey Funeral Home, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850

25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FEB 16 '89	Julia Davidson-Randall

07/84 25M BP 15+1 gals DHMH 17 (VR A15 ME (5))

10

024157 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05462
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: HOWARD	MIDDLE: L.	LAST: GUGEL, JR.	2a. DATE OF DEATH MONTH: 1	DAY: 31	YEAR: 89	2b. HOUR: 1:30P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 11	DAY: 20	YEAR: 21	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.						
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 16608 Jilrick Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Manuf. Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Manufacturing						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 16608 Jilrick Street 20853					
14. FATHER'S NAME FIRST: Howard	MIDDLE: L.	LAST: Gugel, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Martha	MIDDLE:	LAST: Schellhas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 219-18-0818	17. INFORMANT ADDRESS: Veronica Gugel 16608 Jilrick St. 20853						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardiopulmonary arrest	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	metastatic gastric cancer	months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
D. Sidransky MD		

22d. PHYSICIAN'S NAME (PLEASE PRINT)	22e. ADDRESS
Dr. Sidransky	Johns Hopkins Hosp., Out Patient Oncology Clinic

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/3/89	Loudon Park Cemetery	Baltimore		Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home	1331 Rockville Pike 20852	FEB 08'89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 127 (

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05463
REG. NO

23590 FEB 23

1. DECEASED NAME (TYPE OR PRINT): FIRST ROY MIDDLE C. LAST HADE

2a. DATE OF DEATH: MONTH February DAY 11 YEAR 1989

2b. HOUR: 245 AM/PM M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH June DAY 19 YEAR 1907

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE NURSING CTR

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic

12b. KIND OF BUSINESS OR INDUSTRY: Farm Implement

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Penna.

13b. COUNTY: Franklin

13c. CITY OR TOWN: Waynesboro

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 10683 Five Forks Rd. 17268

14. FATHER'S NAME: FIRST David MIDDLE B. LAST Hade

15. MOTHER'S MAIDEN NAME: FIRST Susan MIDDLE LAST Bitner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 167-16-9164

17. INFORMANT: Richard D. Hade ADDRESS: 38 E. Fifth St. Waynesboro, PA 17268

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	~~STOP~~ Respiratory Arrest	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	congestive Heart Failure	months
DUE TO, OR AS A CONSEQUENCE OF (c)	Sideroblastic Anemia	Months.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Mitral + Aortic valvular Insufficiency

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/17 19 89 to 2/11 19 89, that (I) (we) last saw the deceased alive on 2/11 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alan Vinitsky DEGREE MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/11/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN R. VINITSKY

22e. ADDRESS: 12116 DARNESTOWN RD GAITHERSBURG MD 20878

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/13/1989

23c. NAME OF CEMETERY OR CREMATORY: Hade's Church Cem.

23d. LOCATION: CITY OR TOWN Antrim Twp. COUNTY Franklin Co. STATE PA

24. FUNERAL DIRECTOR: [signature]

ADDRESS: 50 S. Broad St. Waynesobor, PA.

25a. DATE REC'D. BY REGISTRAR: FEB 20 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)

024079 FEB 18 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05464

1. DECEASED NAME (TYPE OR PRINT): Josephine Veronica Hanold

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] 2/6/89 — 2b. HOUR: M

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: Nov. 13, 1907 — 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. — IF UNDER 1 YR. MONTHS/DAYS — IF UNDER 24 HRS. HOURS/MIN

2c. DATE PRONOUNCED DEAD: 2/6/89 — 2d. HOUR: 9:15 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4928 Baffin Bay Lane

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: New York — 13b. COUNTY: Queens — 13c. CITY OR TOWN: Queens Village — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 80-47 237th Street/11427

14. FATHER'S NAME: Charles Herweg

15. MOTHER'S MAIDEN NAME: Anna Ludwig

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 053-52-0047

17. INFORMANT: Richard V. Hanold — ADDRESS: 4928 Baffin Bay Lane Rockville, MD 20853

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial disease.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Malnutrition.

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): None

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2/6/89

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. — ADDRESS: 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Feb. 9, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery — 23d. LOCATION CITY OR TOWN: Silver Spring — COUNTY STATE: Maryland

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Rockville, Inc. — 300 West Montgomery Ave. Rockville, MD 20850

25a. DATE REC'D. BY REGISTRAR: FEB 09'89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M DHMH - 17 (VR A15 ME (3))

BP 15

023370 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005465
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP XS

DHMH - 16 50M 4/83
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Ruth	MIDDLE: M.	LAST: Hardesty	2a. DATE OF DEATH MONTH: 01 DAY: 28 YEAR: 89	2b. HOUR: 12 40 PM	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 3 DAY: 01 YEAR: 25	6. AGE (IN YEARS LAST BIRTHDAY): 03 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: Mont. Cty. Schools		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Wheaton	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 11931 Centerhill Street 20902	
14. FATHER'S NAME FIRST: James	MIDDLE: G.	LAST: Abell	15. MOTHER'S MAIDEN NAME FIRST: Minnie	MIDDLE:	LAST: Jenkins
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578-30-1824	17. INFORMANT: Charles V. Hardesty	ADDRESS: Husband	Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Arrest	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic Ovarian Cancer	3 yr
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-30, 19 88, to 1-28, 19 89, that (I) (we) last saw the deceased alive on 1-28, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Frederick G Barr	DEGREE: MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frederick G. Barr, M.D.	22e. ADDRESS: 2101 Medical Park Dr. #211 Silver Spring, Md. 20902		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Jan. 31, 1989	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN: Suitland	COUNTY: Pr. Geo.	STATE: Maryland
24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. ADDRESS: 500 University Blvd., W. Silver Spring, Md. 20901		25a. DATE REC'D. BY REGISTRAR: JAN 30 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

025310 MAR 1 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05466 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
James	G.	Hash	2-12-89	10:20 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	W	02-05-19	70 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Heritage Health Care Ctr.	Maint. Eng.	Pkvw. Gardens

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Pr. Geo.	Seabrook	YES ☒ NO ☐	6120 93rd. Ave. 20706

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Guston		Hash	Ruth		Osborne

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	224-18-7152	Clarence Hash	Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent Oat Cell CA lung

DUE TO, OR AS A CONSEQUENCE OF (c) Cigarette Smoking

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) (COPD) Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/31, 19 89, to present, 19 ____, that I (we) last saw the deceased alive on 2/7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Wilson MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-12-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
NORTON ELSON	0525 Rolecrest Rd (Hagerstville MD)

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/15/89	Maryland Vets. Cem.	Cheltenham, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706	FEB 15 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 60M 7/84 (VRA 15, 4)

024208 FEB 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05467 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: C	LAST: Haskin	2a. DATE OF DEATH MONTH DAY YEAR: 02 22 89	2b. HOUR: 430 A M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 02 13 25	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Minister		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Carroll	13c. CITY OR TOWN: West Minister	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 25 B Washington Lane 1657	
14. FATHER'S NAME FIRST: Harrie	MIDDLE: G	LAST: Haskin	15. MOTHER'S MAIDEN NAME FIRST: Nellie	MIDDLE: R	LAST: Carrick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	IF YES, GIVE WAR OR DATES: WWII	16b. SOCIAL SECURITY NO.: 579-20-8221	17. INFORMANT: Donald Haskin-son	ADDRESS: Rt 1, Box 414 Mechanicville Md 20659	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sepsis (Bacteremia / Fungimia) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF (b): Aspiration Pneumonitis — 2 hrs

DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes Mellitus — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): hypertension Peripheral Vascular Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/19/88, 19__, to 02/22/89, 19__, that (I) (we) last saw the deceased alive on 02/21, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: SK Gupta	DEGREE: MD — ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED: 02/22/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): SK GUPTA, MD	22e. ADDRESS: 9801 Ga Ave, Ste 220 Silver Spg Md 20902		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-25-1989	23c. NAME OF CEMETERY OR CREMATORY: Colesville Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring Montgomery Md.
24. FUNERAL DIRECTOR NAME/ADDRESS: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Sil. Spr. Md.	25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023465 FEB 22 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05463 — REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ERNEST EDWARD HATCHER	FEBRUARY 13 1989	11:15 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	CAUCASIAN	MAY 21 1930	58 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
WEST VIRGINIA	UNITED STATES		MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL	RETIRED	U.S. ARMY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
VIRGINIA	PRINCE WM.	MANASSAS	YES [ ] NO [ ]	7908 GUY DRIVE	22111

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
DAVID ALPHUS HATCHER	MINNIE MAE MILLS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	1946-1966	232-42-9675	ELEANOR A. HATCHER, 7908 GUY DRIVE, MANASSAS, VA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE COLON — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 3, 19 89, to FEBRUARY 13, 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED
James a Butler	M.D.		14 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. A. BUTLER, LCDR, MC, USN	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/17/89	Quantico National	Triangle, Pr. Wm. Co., VA

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donald Kohn Lee Funeral Home	8521 Sudley Rd., Manassas, VA 22110	FEB 21 1989	Jiha Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023652 FEB 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 39 005469

1. DECEASED NAME (TYPE OR PRINT): FIRST Ethel MIDDLE B. LAST Hayman
2a. DATE OF DEATH: MONTH 2 DAY 11 YEAR 89
2b. HOUR 905 pm M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 10 DAY 31 YEAR 94
6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Russia
7b. CITIZEN OF WHAT COUNTRY? American
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Chevy Chase nursing Home and Rehab
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House wife.
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Washington DC
13b. COUNTY
13c. CITY OR TOWN: Washington
13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS / ZIP CODE: 7531 17th Street, N.W. (20012)

14. FATHER'S NAME: FIRST Abraham MIDDLE LAST Bricker
15. MOTHER'S MAIDEN NAME: FIRST Anna MIDDLE LAST Bricker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES): ------
16b. SOCIAL SECURITY NO.: 579-52-0859
17. INFORMANT: Irvin Hayman; Son; 7531 17th Street, N.W.; Wash., D.C. 20012

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable Cardiac event — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8:40 - 9:05 pm
DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerotic cardiovascular disease — years
DUE TO, OR AS A CONSEQUENCE OF (c): Hypertension — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: SYNCOPE, CONFUSION AND HTN

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/10, 19 89, to 2/11, 19 89, that (I) (we) last saw the deceased alive on 2/10, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did) (did not) view the body after death.
22b. SIGNATURE: M Shapiro MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/11/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Morton W Shapiro MD
22e. ADDRESS: 5225 Pooks Hill Rd Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/15/89
23c. NAME OF CEMETERY OR CREMATORY: Ohev Sholom-Talmud Torah; Washington, D.C.
23d. LOCATION: CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS
ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852
25a. DATE REC'D. BY REGISTRAR: FEB 17 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84 (VRA 15, 4)

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR. After this certificate has been signed by the physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

025283 MAR 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05470
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alvin	MIDDLE: E.	LAST: Hazard	2a. DATE OF DEATH MONTH DAY YEAR: 2-14-89	2b. HOUR: 3:52 P.M.	
3. SEX: MALE	4. RACE: C 1	5. DATE OF BIRTH MONTH DAY YEAR: 3-23-13	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CALIFORNIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CAPTAIN	12b. KIND OF BUSINESS OR INDUSTRY: DC FIRE DEPT		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: ROCKVILLE	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 257 CONGRESSIONAL LANE #210	20852
14. FATHER'S NAME FIRST: CHARLES	MIDDLE: M.	LAST: HAZARD	15. MOTHER'S MAIDEN NAME FIRST: BESSIE	MIDDLE: MAE	LAST: BILLER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 576-10-5968	17. INFORMANT ADDRESS: GENEVIEVE F. HAZARD/WIFE/SAME AS 13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary arrest	25 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Acute myocardial infarction	12 hours
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary artery disease	10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 89 to 2/14 19 89, that (I) (we) last saw the deceased alive on 2/14 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Samuel Goldberg MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-15-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Samuel P. Goldberg, MD — 22e. ADDRESS: 6410 Rockledge Dr. Bethesda md 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 17,1989	23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: BRENTWOOD PRINCE GEORGES MD
24. FUNERAL DIRECTOR NAME / ADDRESS: FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 17'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

024148 FEB 29 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05471 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove data processing papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other violent event, the medical examiner may be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Mary; MIDDLE: A.; LAST: HEALEY		2a. DATE OF DEATH — MONTH DAY YEAR: FEB 2 1989	2b. HOUR: 11:37 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH — MONTH DAY YEAR: May 17, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mass.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Retirement Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Claim Examiner	12b. KIND OF BUSINESS OR INDUSTRY: US Gov't.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: ---	13b. COUNTY: ---	13c. CITY OR TOWN: Washington, DC	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 2929 Connecticut Ave, NW/20008
14. FATHER'S NAME — FIRST: Thomas; MIDDLE: J.; LAST: Healey		15. MOTHER'S MAIDEN NAME — FIRST: Bridget; MIDDLE: --; LAST: Connell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ---	16b. SOCIAL SECURITY NO.: 579-46-7454	17. INFORMANT: Edmund A. Healey, Boston, Mass.	ADDRESS: 12 Sachem St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Large Cerebral Thrombosis	2 mos
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral arteriosclerosis	10 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Diabetes Mellitus	10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Decubitis (Lumbosacral & Lt forearm

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 89, to Feb. 3, 19 89, that (I) (we) last saw the deceased alive on Feb 1, 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas F. McMahon MD	DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-3-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas F. McMahon	22e. ADDRESS: 2737 Devonshire Pl, NW, Washington, D.C.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/6/89	23c. NAME OF CEMETERY OR CREMATORY: Mount Benedict	23d. LOCATION — CITY OR TOWN, COUNTY, STATE: Boston, Mass.
24. FUNERAL DIRECTOR NAME AND ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-10-50M 1/81 (VRA 15, 4)

023377 FEB 2 1989

STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005472 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in obtaining the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alexander	MIDDLE: Pete	LAST: Heilweil	2a. DATE OF DEATH MONTH DAY YEAR: Feb. 1, 1989	2b. HOUR: 815 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 27, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NY	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Collingswood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Mont.	Beth.	YES ☒ NO ☐	5101 River Rd. 20816

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Frank / / Heilweil	Minnie / / Siebert

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW II	109-22-9456	Roslyn Heilweil Same as item # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bronchopneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-18, 19 88, to 2-1, 19 89, that (I) (we) last saw the deceased alive on 1-34, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2-1-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Tauber	8218 Wisconsin Ave, Bethesda, MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/3/89	King David Mem. Gdns.	Falls Church, VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016	FEB 02 '89	[signature] Davidson-Randall

023651 FEB 23 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05473 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: HELEN	MIDDLE	LAST: HELWITZ	2a. DATE OF DEATH MONTH DAY YEAR: February 14, 1989		2b. HOUR: 9:35a M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: July 27, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	901 Arcola Avenue (20902)

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Samuel / / Block	Fannie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	------	114-10-9709	William Barrett;Son-in-Law;6471 Wishbone Terrace; Cabin John,Md.20818

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gram negative Sepsis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Dys

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardiovascular Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/6, 19 87, to 2/14, 19 89, that (I) (we) last saw the deceased alive on 2/14, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Myron Lenkin	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb.14, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MYRON L. LENKIN, M.D.	2309 Shorefield Road;Wheaton, Md. 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/16/89	King David Mem. Garden	Falls Church; Farifax;Va.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	FEB 17 1989	Julia Trindon Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024154 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05474
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The information required in this certificate should be recorded at the time of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

BP 20th

DHMH - 16.50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: John	MIDDLE: C	LAST: HERBERG, JR.	2a. DATE OF DEATH MONTH DAY YEAR: 01 30 1989	2b. HOUR: 845 AM	
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: FEB 1 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MINNESOTA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ATTORNEY	12b. KIND OF BUSINESS OR INDUSTRY: US SENATE LEGISLATIVE COUNSEL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 404 HAMILTON AVENUE 20901	
14. FATHER'S NAME FIRST: JOHN	MIDDLE: C.	LAST: HERBERG, SR.	15. MOTHER'S MAIDEN NAME FIRST: HILDA	MIDDLE	LAST: WARNDAHL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	IF YES, GIVE WAR OR DATES: WWII	16b. SOCIAL SECURITY NO.: 213-38-4121	17. INFORMANT ADDRESS: GRACE T. HERBERG/WIFE/SAME AS 13		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIORESPIRATORY ARREST	5 min
DUE TO, OR AS A CONSEQUENCE OF (b)	GASTROINTESTINAL BLEEDING	TWO
DUE TO, OR AS A CONSEQUENCE OF (c)	? SEPSIS.	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROTIC STATE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 7/11 19 88 to 1130 19 89, that (I) (we) last saw the deceased alive on 1138 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED:

22a. PHYSICIAN'S NAME (TYPE OR PRINT): EDWARD A. LEVIN

22e. ADDRESS: 4801 Montgomery

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 2, 1989	23c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY	23d. LOCATION CITY OR TOWN: WASHINGTON, DC	COUNTY / STATE
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

023944 FEB 28 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 05475

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: BARNEY JOSEPH KEREN				2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 16, 1989	2b HOUR: 7:45 PM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JULY 17, 1907		6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒		9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH: ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME OF GREATER WASHINGTON			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ATTORNEY	12b. KIND OF BUSINESS OR INDUSTRY: LAW

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 20016

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
OF COLUMBIA	None	WASHINGTON	YES ☒ NO ☐	2801 NEW MEXICO AVENUE, N. W.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
KUSIEL KEREN	MARY	BAICOVITZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		225-52-5585	PAT MANNING,	5829 LIPTON STREET McLEAN, VIRGINIA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory arrest	seconds
DUE TO, OR AS A CONSEQUENCE OF (b)	Intracranial Hypertension	Days
DUE TO, OR AS A CONSEQUENCE OF (c)	Astrocytoma	years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 2-16 19 89 to 2-16 19 89, that (I) (we) last saw the deceased alive on 2-16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: FEB. 17, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Daniel A Galla MD 22e. ADDRESS: 6121 MONTROSE ROAD ROCKVILLE, MARYLAND 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	2/18/1989	METROPOLITAN CREMATORY	ALEXANDRIA VIRGINIA

24. FUNERAL DIRECTOR (NAME / ADDRESS): DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR: FEB 24 1989 25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023331 FEB 22 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05476
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
CLARENCE ALVIN HEURING	FEBRUARY 2 1989	1:30 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	CAUCASIAN	MAY 22 1929	59 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
ILLINOIS	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL		U.S.A.F.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
DELAWARE	SUSSEX	LEWES	YES [ ] NO [ ]	5 SAND DUNE DRIVE	19958

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
WILLIAM THEON HEURING	EVELYN POHLIT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	1947-1967	330-24-1364	HATSUKO HEURING, 5 SAND DUNE DRIVE, LEWES, DE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF COLON

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES [ ] NO [X]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 27 19 89 to FEBRUARY 2 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
D B Robinson	M.D.	[ ] [ ] [X]	2 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
D. B. ROBINSON, LCDR, MC, USNR	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 7, 1989	ARLINGTON NATL CEM	ARLINGTON VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 06 '89	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

23127 FEB 17 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05477
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alfred / ALFRED; MIDDLE: A / A.; LAST: HIGGINS / HIGGINS, Sr.		2a. DATE OF DEATH MONTH DAY YEAR: 2 / 13 / 89	2b. HOUR: 1040 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 26, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mason	12b. KIND OF BUSINESS OR INDUSTRY: County schools

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Damascus	YES [ ] NO [X]	26620 Howard Chapel Dr. 20872

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: Howard; MIDDLE: M.; LAST: Higgins	FIRST: Libbie; MIDDLE: ; LAST: Allnutt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		220-28-6505	Mary M. Higgins,	Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO-RESPIRATORY ARREST. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): LEAKING ANEURYSM & BLEEDING - ASCENDING AORTA

DUE TO, OR AS A CONSEQUENCE OF (c): CORONARY ARTERY DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPERTENTION, CHRONIC RENAL FAILURE -

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 19 86, to Feb 13 19 89, that (I) (we) last saw the deceased alive on February 13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) [did not] view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
	MD	[ ] [X] [ ]	2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARIO O. BELLEDONNE	14816 PHYSICIANS LANE 251

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 15, 1989	Laytonsville	Laytonsville, Montgomery, Md.

24. FUNERAL DIRECTOR NAME, ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Olin L. Molesworth, P.A., Damascus, Md.	FEB 15 1989	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023176 FEB 19 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05473 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Hannah MIDDLE R. LAST Hirsch

2a. DATE OF DEATH: MONTH DAY YEAR February 10, 1989

2b. HOUR 9:00 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH DAY YEAR October 24, 1922

6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY? U. S. A.

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1306 Dale Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 1306 Dale Drive 20901

14. FATHER'S NAME: FIRST Morris MIDDLE LAST Rubinstein

15. MOTHER'S MAIDEN NAME: FIRST (Unknown) MIDDLE LAST (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 089-14-4331

17. INFORMANT: Stanley I. Hirsch ADDRESS (Same as # 13)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): cardiorespiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b): adeno carcinoma of breast — 9 months

DUE TO, OR AS A CONSEQUENCE OF

(c): hyper calcemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO XXX

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July, 19 88, to February 10 19 89, that (I) (we) last saw the deceased alive on February 7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Otis W Brawley — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/11/1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Otis Brawley, M. D.

22e. ADDRESS: 1900 Lyttonsville Road, Apt. 708 Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/15/1989

23c. NAME OF CEMETERY OR CREMATORY: Judean Mem. Gardens

23d. LOCATION: CITY OR TOWN Olney, COUNTY Montgomery, STATE Md.

24. FUNERAL DIRECTOR: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D BY REGISTRAR: FEB 15 1989

25b. REGISTRAR'S SIGNATURE: Paula Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

P

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

024424 MAR - 2 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05479
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trouble event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Clinton	M.	Hisle Jr.	February 7, 1989	9:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	Caucasian	03 25 1904	84 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington DC	U.S.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Kensington	9804 Cable Drive	Retired Accountant	Fed. Gov't.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Mont.	Kensington	YES ☒ NO ☐	9804 Cable Drive 20895

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Clinton	M.	Hisle, Sr	Johanna		Scanlon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		579-10-9107	Ann M. Kain	819 Brice Road, Rockville, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIO PULMONARY ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Artery Disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
DIABETIC NEUROPATHY, CHRONIC BRONCHITIS, Atrial Fibrillation.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from May, 19 87, to 2/7 19 89, that (I) (we) last saw the deceased alive on 1/31 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Irving Mizus, M.D., FCCP	5413 Cedar Lane, Suite 206-C

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Removal	02-07-89	Georgetown Med. School	Washington D.C.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert G. Mason	1661 Good Hope Road, S.E.	FEB 27 1989	Julia Davidson-Randall

DHMH 1660M 1/73
(VR A 15 (4))

123327 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005480
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Robert / Emmett / Holt			2a. DATE OF DEATH — MONTH / DAY / YEAR	02 / 06 / 89
2b. HOUR	4:50AM				
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH — MONTH / DAY / YEAR	June 26 1912
6. AGE (IN YEARS LAST BIRTHDAY)	76 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Virginia	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery MD.				
10. CITY OR TOWN OF DEATH	Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired Rockv. City
12b. KIND OF BUSINESS OR INDUSTRY	License Inspector				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Montgomery	13c. CITY OR TOWN	Silver Spring
13d. INSIDE CITY LIMITS?	YES XX NO ☐	13e. STREET ADDRESS	3510 Forest Edge Dr. # 1-G 20906		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Russell / A. / Holt	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Margaret / Whitehead		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	N/A	(IF YES, GIVE WAR OR DATES)	N/A	16b. SOCIAL SECURITY NO.	578-07-1390
17. INFORMANT — ADDRESS	Doris Holt-wife- (same as 13e)				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CORONARY ARTERY DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from February 2, 19 89, to February 6, 19 89, that (I) ~~(we)~~ last saw the deceased alive on February 5, 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ did (did not) view the body after death.

22b. SIGNATURE: Barry Hecht — DEGREE: M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: February 6, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BARRY HECHT — 22e. ADDRESS: 3941 FERRARA DRIVE WHEATON, MD 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	2-8-1989	23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Burtonsville Montgomery Md.			
24. FUNERAL DIRECTOR AND ADDRESS	Hines/Rinaldi Funeral Home 14800 N.H. Ave. Silver Spring, Md.	25a. DATE REC'D. BY REGISTRAR	FEB 07'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

025344 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05481
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Ida MIDDLE B. LAST HONEGGER

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH Feb DAY 21 YEAR 19 89 — 2b. HOUR 1145 A.M. P.M.

3. SEX F — 4. RACE W — 5. DATE OF BIRTH MONTH Oct DAY 25 YEAR 03 — 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH Feb DAY 24 YEAR 19 89 — 2d. HOUR 1245 A.M. P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomer MD.

10. CITY OR TOWN OF DEATH: Silver Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD — 13b. COUNTY Mont. — 13c. CITY OR TOWN Silver Spg — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS 10010 Portland Pl 20901

14. FATHER'S NAME: FIRST CHARLES MIDDLE LAST BRUECK

15. MOTHER'S MAIDEN NAME: FIRST BARBARA MIDDLE LAST ENDRES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 212-74-4273

17. INFORMANT ADDRESS: EUGENE H. HONEGGER/HUSBAND/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Inf

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Myocardial Dis

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic Renal Failure

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER DATE SIGNED: Feb 24 1989

EXAMINER'S NAME (TYPE OR PRINT): JOHN S. ROGERS, M.D. ADDRESS: 1919 SEMINARY ROAD SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: FEB 25, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM. — 23d. LOCATION CITY OR TOWN: SILVER SPRING COUNTY: MONTGOMERY STATE: MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25a. DATE REC'D. BY REGISTRAR: FEB 24 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M

BP 12

DHMH - 17 (VR A15 ME (5))

023374 FEB 22 89 P

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005482
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 — The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT:

BP 15

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Russell / E. / Hoover	2a. DATE OF DEATH — MONTH DAY YEAR	January 27, 1989	2b. HOUR	10:50AM
3. SEX	Male	4. RACE	Caucasian	5. DATE OF BIRTH — MONTH DAY, YEAR	December 20, 1905
6. AGE (IN YEARS LAST BIRTHDAY)	83 YRS	IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS. — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Illinois	7b. CITIZEN OF WHAT COUNTRY?	United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery County, MD.				
10. CITY OR TOWN OF DEATH	Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Potomac Valley Nursing Home	12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED)	Assistant Sales Manager
12b. KIND OF BUSINESS OR INDUSTRY	Regis Paper Company				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES ☐ NO ☒	7908 Sleaford Place 20814

14. FATHER'S NAME — FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
Earl / Roy / Hoover	Nell / Gray	No	326-01-3727	Robert N. Hoover, Son, Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest, Pulmonary arrest	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Recurrent aspiration Pneumonia	3 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Alzheimer's Disease End Stage	8 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from August 19 88, to January 27 19 89, that (I) (we) last saw the deceased alive on January 27 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Lee R. Pennington	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Jan. 27, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Lee R. Pennington, M.D.	8218 Wisconsin Avenue Bethesda, Maryland 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	Jan. 30, 1989	All Saints Cemetery	Des Plains, Illinois

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814	JAN 31 '89	Julia Davidson-Randall

023132 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005483

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Lillian	Middle: B.	Last: Hudes	
2a. DATE OF DEATH Month: 2 Day: 11 Year: 89	2b. HOUR 9514 M		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month: February Day: 1, Year: 1921	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York City	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Schools
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS: # 12 1400 Hampshire West Court 20903			
14. FATHER'S NAME First: Nathan Middle: Last: Breitholz	15. MOTHER'S MAIDEN NAME First: Jennie Middle: Last: Oliver		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 062-16-4059	17. INFORMANT: Paul B. Hudes	ADDRESS: 11504 Lockwood Drive, Apt A-2 Silver Spring, Md. 20904

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	5 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Aspiration	1 hour
DUE TO, OR AS A CONSEQUENCE OF (c)	Cancer	2 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Dec 19 88 to 11 Feb 19 89, that I (we) last saw the deceased alive on 11 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 11 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael Leibach, MD 22e. ADDRESS: 11120 New Hampshire Ave Silver Spring Md 20904

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/14/1989	23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Garden	23d. LOCATION CITY OR TOWN: Falls Church, COUNTY / STATE: Virginia	
24. FUNERAL DIRECTOR NAME: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME ADDRESS: 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025285 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005481
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Calvin	MIDDLE: C.	LAST: Hughes	2a. DATE OF DEATH MONTH DAY YEAR: 2-15 89		2b. HOUR: 2:05 AM
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 12 05 24	6. AGE (IN YEARS LAST BIRTHDAY) YRS: 64	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Florida	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Director of C.E.	12b. KIND OF BUSINESS OR INDUSTRY: University		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
D.C.		Washington	YES [X] NO [ ]	1412 Primrose Rd. N.W.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Dr. Richard S. Hughes, Sr.	Hermie LaRoche

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	6-9-43/2-46	262-28-9792	Ollie B. Hughes	1412 Primrose Rd. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory Arrest	2 mins
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral Hemmorhage	3DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	Malignent Hypertension	3DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Aortic Dissection, Renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/09/89	Aortic Dissection	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from November 1, 19 88, to February 15, 19 89, that (I) (we) last saw the deceased alive on February 15, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Raymon Nelson	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2-15-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Raymon Nelson, MD	1160 Varnum St Suite 208

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-20-89	Ft. Lincoln Cemetery	Brentwood, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
McGuire Funeral Service, Inc.	7400 Georgia Ave. Washington, D.C.	FEB 17 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 20

DHMH-16 50M 1/81 (VRA 15, 4)

024166 FEB 2 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05485 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Marie	MIDDLE: B.	LAST: Jackson	2a. DATE OF DEATH MONTH DAY YEAR: February 2, 1989	2b. HOUR: 120 A M	
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH MONTH DAY YEAR: August 3, 1892	6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Potomac Valley Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housekeeper	12b. KIND OF BUSINESS OR INDUSTRY: Domestic		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 8701 Bradmoor Dr./20817	
14. FATHER'S NAME FIRST: John	MIDDLE:	LAST: Little	15. MOTHER'S MAIDEN NAME FIRST: Anna	MIDDLE:	LAST: Spears
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 235 12 1015	17. INFORMANT (Daughter) ADDRESS: Marie J. Bourgeois Same as line #13.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 25 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 3-3- 1977 to 2-2- 1989, that (I) (we) last saw the deceased alive on 1-27- 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen W. Dejter DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: February 02, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen W. Dejter, M.D. — 22e. ADDRESS: 6719 Wilson Lane Bethesda, Md. 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 4, 1989	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN: Silver Spring	COUNTY / STATE: Maryland

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR: FEB 06 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

022410 FEB 13 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005486
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Sindy Middle: M. Last: Jacobs		2a. DATE OF DEATH Month Day Year: 02/06/89	2b. HOUR: 1200 PM
3. SEX: F	4. RACE: W	5. DATE OF BIRTH Month Day Year: 10 06 21	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TEXAS	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BANK TELLER	12b. KIND OF BUSINESS OR INDUSTRY: BANKING
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: MONT.	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 102 MELBOURNE AVE 20901			
14. FATHER'S NAME First: PETER Middle: Last: TODORA		15. MOTHER'S MAIDEN NAME First: ANNIE Middle: Last: CAMPISI	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 465-18-2398	17. INFORMANT: GARY JACOBS	ADDRESS: 102 MELBOURNE AVE S.S. MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio pulmonary Arrest	8 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Hepatic Coma	52 hr.
DUE TO, OR AS A CONSEQUENCE OF (c)	Congestive Heart Failure	60 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypocalcemia, Spasm

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I **certify** that (I) (this hospital) attended the deceased from 3 Jan 89 19 89 to 6 Feb 19 89, that (I) (we) last saw the deceased alive on 6 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Anthony P. Zavadil III	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 6 Feb 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Anthony Zavadil	22e. ADDRESS: 7610 Carroll Ave, Takoma Pk Md.		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 10. 1989	23c. NAME OF CEMETERY OR CREMATORY: Restland Memorial Park	23d. LOCATION CITY OR TOWN: Dallas / COUNTY / STATE: Texas
24. FUNERAL DIRECTOR NAME: Takoma Funeral Home, Inc. Walter	ADDRESS: 257 Carroll Ave DC	24a. DATE REC'D BY REGISTRAR: FEB 8 1989	25b. REGISTRAR'S SIGNATURE: Davidson-Randall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

023653 FEB 23 88

89 05437 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST DOROTHY MIDDLE R. LAST JACOBSON

2a. DATE OF DEATH: MONTH 2 DAY 14 YEAR 89 — 2b. HOUR 9A M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH Dec. DAY 24 YEAR 1915

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penn. Wilkes-Barre

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Chevy Chase

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4450 South Park Avenue, #204

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Chevy Chase — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 4450 S. Park Ave. #204 — 20815

14. FATHER'S NAME: FIRST Harry MIDDLE LAST Robin

15. MOTHER'S MAIDEN NAME: FIRST Sarah MIDDLE LAST Wein

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 203-05-4460

17. INFORMANT ADDRESS: Steve Jacobson; 88 Norwood Ave. Glen Rock, N

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocandial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease — 8 years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1980 19__ to Feb 19 89, that (I) (we) last saw the deceased alive on 2/13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wesley B. Mason — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wesley B. Mason

22e. ADDRESS: 10810 Connecticut Ave, Kensington, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/16/89

23c. NAME OF CEMETERY OR CREMATORY: W. Pittston Cem.

23d. LOCATION: CITY OR TOWN W. Pittston COUNTY Luzerne STATE Pa

24. FUNERAL DIRECTOR: NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS; 1170 ROCKVILLE PIKE ROCKVILLE, MD. 20852

25a. DATE REC'D. BY REGISTRAR: FEB 17 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked on Item 18 show any injury, poisoning or other violent or traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The remaining carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

025290 MAR 1 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005483
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 4/83
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Suoma / Johanna / Lehtinen Jämsen		2a. DATE OF DEATH — MONTH DAY YEAR	February 16, 1989 11:28AM (2b. HOUR)
3. SEX	Female	4. RACE: White	5. DATE OF BIRTH — MONTH DAY YEAR	March 12, 1940
6. AGE (IN YEARS LAST BIRTHDAY)	48 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Finland	7b. CITIZEN OF WHAT COUNTRY?	Finland	
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery County, MD.	
10. CITY OR TOWN OF DEATH	Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	5011 Rockmere Court	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Pharmacist	12b. KIND OF BUSINESS OR INDUSTRY	Hospital	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Bethesda	YES [ ] NO [X]	5011 Rockmere Court 20816

14. FATHER'S NAME — FIRST / MIDDLE / LAST	Lauri / Antero / Lehtinen	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Aune / Paananen
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	No	16b. SOCIAL SECURITY NO.	None
17. INFORMANT — ADDRESS	Kauko Jämsen, Husband, Same as item #13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma of the Breast (5-87)	21 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I [X] (this hospital) attended the deceased from February 2, 19 89, to February 16, 19 89, that I [X] (we) last saw the deceased alive on February 15, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I [X] (we) (did) [XXX] (did not) view the body after death.

22b. SIGNATURE — DEGREE	Richard W Holt, MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED	Feb.16,1989
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Richard W. Holt, M.D.	22e. ADDRESS	3800 Reservoir Rd., N.W.,Wash.,D.C. 20007	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	2-28-89	Vanhaukirken Hautausmaa	Espoo, Finland

24. FUNERAL DIRECTOR — NAME / ADDRESS	Rapp Funeral Services, P. A. / 933 Gist Avenue, Silver Spring, MD 20910	25a. DATE REC'D. BY REGISTRAR	FEB 16'89	25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall

Items 18a, 22a per M.E. Film

024733 MAR 1 08 G650 4/26/89 CG Part 2

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005489

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
PENALTY FOR FALSE VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Ralph	MIDDLE: Julian	LAST: Jones	2a. DATE KNOWN OF DEATH / ESTIMATED	MONTH: XX	DAY: 2	YEAR: 22-89 19	2b. HOUR: M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH: MONTH 8 DAY 18 YEAR 39	6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS.	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 22- YEAR 19 89	2d. HOUR: 12:04 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.					
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Construction					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE: Maryland	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: Oxon Hill	13d. INSIDE CITY LIMITS? YES X / NO	13e. STREET ADDRESS: 2214 Alice Ave. #201				
14. FATHER'S NAME: FIRST Percy	MIDDLE	LAST Jones	15. MOTHER'S MAIDEN NAME: FIRST Gloria	MIDDLE	LAST Hodges			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Unk.	16b. SOCIAL SECURITY NO.: 162-30-3795	17. INFORMANT: Twana Stanley	ADDRESS: 2214 Alice Ave.-Oxon Hill, Maryland				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	hypotensive arteriosclerotic	
DUE TO, OR AS A CONSEQUENCE OF (b)	Cardiovascular disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Chronic narcotic use

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES XX / NO
21a. EXTERNAL CAUSE WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner.

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER DATE SIGNED 2-23-89

VC EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2-27-89	Lincoln Mem. Cemetery	Suitland, Maryland	
24. FUNERAL DIRECTOR NAME / ADDRESS: Alexander S. Pope-2617 Pennsylvania Ave. S.E.		25a. DATE REC'D. BY REGISTRAR: MAR 2 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

07/84 25M BP 403

DHMH - 17 (VR A15 ME (5))

024082

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 054900

1. DECEASED NAME (TYPE OR PRINT) — FIRST: SELVANATHAN — MIDDLE: — LAST: KADIRGAMAR

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ — MONTH: 2 — DAY: 10 — YEAR: 19 89 — 2b. HOUR: 9:21 AM

3. SEX: MALE — 4. RACE: Caucasian — 5. DATE OF BIRTH: MONTH Nov. DAY 23, YEAR 1920 — 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 10 YEAR 19 89 — 2d. HOUR: 9:21 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Sri Lanka — 7b. CITIZEN OF WHAT COUNTRY?: United States — 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co., MD.

10. CITY OR TOWN OF DEATH: Bethesda — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Personnel Manager — 12b. KIND OF BUSINESS OR INDUSTRY: Employment Agency 20852

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Rockville — 13d. INSIDE CITY LIMITS? YES ☐ NO XX — 13e. STREET ADDRESS: 10500 Rockville Pike, #216

14. FATHER'S NAME — FIRST: Samuel — MIDDLE: J. C. — LAST: Kadirgamar

15. MOTHER'S MAIDEN NAME — FIRST: Parimalam — MIDDLE: — LAST: Mather

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 024-46-8168

17. INFORMANT — ADDRESS: Mrs. Lilanie Geiger, Daughter, 778 High Meadow Drive, Toms River, NJ 08753

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Respiratory arrest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c): Hypertensive Heart Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Tauber — M.D. — TITLE (SPECIFY): Deputy Medical Examiner — DATE SIGNED: 2-10-89

EXAMINER'S NAME (TYPE OR PRINT): John Tauber — ADDRESS: 8218 Wisconsin Ave Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: Feb. 14,1989 — 23c. NAME OF CEMETERY OR CREMATORY: Montgomery Crematorium, Inc. — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bethesda, Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR: FEB 13'89 — 25b. REGISTRAR'S SIGNATURE: Lisa Davidson-Randell

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 7

DHMH - 17 (VR A15 ME (5))

025276 MAR 1 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05491
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST NAZARETH MIDDLE B. LAST KALEMKIARIAN
2a. DATE OF DEATH: MONTH 2 DAY 14 YEAR 89
2b. HOUR: 7 35 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH Nov. DAY 9 YEAR 1909
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Turkey
7b. CITIZEN OF WHAT COUNTRY?: Sudan
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Photographer
12b. KIND OF BUSINESS OR INDUSTRY: Self-employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Mont. [illegible]se
13c. CITY OR TOWN: Chevy Chase
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 4601 N Park Ave. 20815

14. FATHER'S NAME: FIRST Boghos MIDDLE LAST Kalemkiarian
15. MOTHER'S MAIDEN NAME: FIRST Hanem MIDDLE LAST (Unknown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 217-02-4342
17. INFORMANT ADDRESS: Mary B. Kalemkiarian Same as ite,m # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-6, 19 89, to 2-14, 19 89, that (I) (we) last saw the deceased alive on 2-14, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: James H. Brodsky DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2-15-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): James H. Brodsky, MD
22e. ADDRESS: 4701 Willard Ave Chevy Chase MD 20815

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-18-89
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION CITY OR TOWN: Silver Spring, COUNTY: MD STATE:
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 WI Ave. NW Wash., DC CODE: 20016
25a. DATE REC'D. BY REGISTRAR: FEB 17'89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

025315 MAR 1 1989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05492 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Caroline — MIDDLE: — LAST: Kaplan

2a. DATE KNOWN OF DEATH ESTIMATED — MONTH: Feb — DAY: 25 — YEAR: 19 89 — TIME: 2200 A.M.

3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH — MONTH: Aug — DAY: 05 — YEAR: 83 — 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD — MONTH: Feb — DAY: 25, — YEAR: 19 89 — TIME: 2215 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Merchant

12b. KIND OF BUSINESS OR INDUSTRY: Liquor Store

USUAL RESIDENCE (IF INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Silver Spg. — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 2020 Univ Blvd W Apt 210

14. FATHER'S NAME — FIRST: Jack — MIDDLE: — LAST: Milkis

15. MOTHER'S MAIDEN NAME — FIRST: Yetta — MIDDLE: — LAST: (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 578-52-8887A

17. INFORMANT — ADDRESS: 3201 Brooklawn Terrace
Marcia H. Goldberg Chevy Chase, Md. 20815

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infi. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Myocardial Disf.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Feb 25, 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M. D. — ADDRESS: 1919 Seminary Road, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2/26/1989 — 23c. NAME OF CEMETERY OR CREMATORY: Ohev Sholom Talmud Torah Congregation — 23d. LOCATION CITY OR TOWN: Washington, COUNTY: — STATE: D. C.

FUNERAL DIRECTOR (NAME): DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME — ADDRESS: 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D BY REGISTRAR: MAR 1 - 1989 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025338 MAR 16 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05493
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alice	MIDDLE: Freeman	LAST: Kennedy	2a. DATE OF DEATH MONTH DAY YEAR: February 16, 1989	2b. HOUR: 10:05 PM	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: May 22, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Michigan	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Retirement & Nursing Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 5601 Northfield Rd./20817	
14. FATHER'S NAME FIRST: Henry	MIDDLE: B.	LAST: Freeman	15. MOTHER'S MAIDEN NAME FIRST: Effie	MIDDLE:	LAST: Gibbard
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 215 33 3081	17 INFORMANT: (Son)	ADDRESS: 1600 Day Drive Bruce Freeman Kennedy Carmichael, Ca.95608	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Cardiovascular Disease	years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Carcinoma endometriosis, Depression, Chronic Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~XXXXXX~~ attended the deceased from June 23, 19 75, to February 16, 19 89, that (I) (~~XX~~) last saw the deceased alive on February 14, 19 89, and that in (my) ~~XX~~ opinion death occurred on the date and hour and from the causes stated above, (I) (~~XXXXX~~ (did not) view the body after death.

22b. SIGNATURE: Horace Bernton	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: February 17, 1989	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Horace W. Bernton, M.D.	22e. ADDRESS: 4743 Bradley Blvd., Chevy Chase, MD 20815		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: February 23, 1989	23c. NAME OF CEMETERY OR CREMATORY: Montgomery Crematorium, Inc.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bethesda/Montgomery/Maryland
24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814	25a. DATE REC'D. BY REGISTRAR: FEB 24 '89	25b. REGISTRAR'S SIGNATURE: Gusha Davidson-Randall	

BP 12

DHMH - 16 60M 7/84
(VRA 15, 4)

025333 MAR 16 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005494
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Lelia	Ogston	Kent	Feb. 23, 1989	10 a M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	White	Aug 26, 1918	70 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Dist. of Columbia	U.S.A.		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	4912 Brookeway Drive	Head Cashier	University

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES ☒ NO ☐	4912 Brookeway Drive

20816

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Alfred	James	Ogston	Lucy	Virginia	Russell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		125-10-0841	Catherine Griggs, 4511 Sangamore Ct., Bethesda MD 20816

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory arrest	unknown
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Coronary artery disease aortic aneurysm recent myocardial infarction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from November, 19 88, to 2/23, 19 89, that (I) ~~(we)~~ last saw the deceased alive on 12/29, 19 88, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Karen Stark	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Karen Stark	3800 Reservoir Rd, NW, Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-27-89	Ivy Hill Cemetery	Alexandria, Alexandria, VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. NW, Washington, DC 20016	FEB 24 '89	Julia Davidson-Randell

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

023392 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05495
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Robert	Middle: S.	Last: Keyes	2a. DATE OF DEATH Month/Day/Year: 01 29 89	2b. HOUR: 932 A M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month/Day/Year: 05 06 23	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Nebraska	7b. CITIZEN OF WHAT COUNTRY?: U.S	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	11802 Dewey Road 20906

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Cleon C. Keyes	Pearl Robson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	505-20-8489	Ellen B. Keyes (wife)	same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY FAILURE	5 days
DUE TO, OR AS A CONSEQUENCE OF (b)	METASTATIC CARCINOMA	9 month
DUE TO, OR AS A CONSEQUENCE OF (c)	CARCINOMA OF ESOPHAGUS	3 1/2 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I **certify** that (I) (this hospital) attended the deceased from OCT 20, 19 95, to JAN 29, 19 89, that (I) (we) last saw the deceased alive on JAN 29 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Eugene P. Libré	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	30 JAN 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
EUGENE P. LIBRÉ MD	10400 Connecticut Ave Kensington, Md. 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	1/31/89	Mt. Comfort Crematory	Alexandria, Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home, Inc. 1331 Rockille Pike, Rockville, Md. 20852	JAN 31 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 1041

DHMH - 1650M 1/81 (VRA 15, 4)

024084 FEB 23 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05496
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: RALPH	MIDDLE: E.	LAST: KLEININNA	2a. DATE OF DEATH MONTH DAY YEAR: 2 9 89	2b. HOUR: 2:31 PM	
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: 1 20 28	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: U S A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTG CO. MD.		
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CHIROPRACTOR	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: MONTG	13c. CITY OR TOWN: WHEATON	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 12105 VIERS MILL RD. 20906	
14. FATHER'S NAME FIRST: ELMER	MIDDLE: S.	LAST: KLEININNA	15. MOTHER'S MAIDEN NAME FIRST: MARY	MIDDLE: REIMERT	LAST: LA ROSE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 339-26-5142	17. INFORMANT: HARRIET L. KLEININNA	ADDRESS: WIFE SAME AS 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 HR.
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/9 19 89 to 2/9 19 89, that (I) (we) last saw the deceased alive on 2/9 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas H. Burguieres M.D. DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): THOMAS H. BURGUIERES, M.D.
22e. ADDRESS: HOLY CROSS HOSPITAL S.S. MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 14, 1989	23c. NAME OF CEMETERY OR CREMATORY: TRINITY REFORMED UNIT. CHURCH OF CHRIST CEM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: COLLEGEVILLE MONTGOMERY PENN.

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901
25a. DATE REC'D. BY REGISTRAR: FEB 13 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Signed by UK Forms

BP 15 + 1gun salute

DHMH - 1650M 1/81 (VRA 15, 4)

023360 FEB 2 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05497
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CORA MIDDLE: V. LAST: KING			2a. DATE OF DEATH MONTH DAY YEAR: February 2, 1989 — 2b. HOUR: M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: Nov 9, 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 8304 McCullough Lane #301	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife .	12b. KIND OF BUSINESS OR INDUSTRY: None
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Montg.	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 8304 McCullough Lane, 301 20877
14. FATHER'S NAME FIRST: Albert MIDDLE LAST: Baker		15. MOTHER'S MAIDEN NAME FIRST: Maggie MIDDLE LAST: Martin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-32-2217	17. INFORMANT: Mrs Margaret M. Howard — ADDRESS: 811 Westmore Ave Rockville, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of pancreas — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mo
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Common bile duct obstruction; Glucose intolerance

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 23 Nov 19 88, to 2 Feb 19 89, that (I (~~we~~) last saw the deceased alive on 25 Dec 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: Donald E. Dillon MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Donald E. Dillon MD — 22e. ADDRESS: 9900 O'Neil - Sandy Spring Rd 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-7-89	23c. NAME OF CEMETERY OR CREMATORY: Lincoln Park Cem.	23d. LOCATION (CITY OR TOWN / COUNTY / STATE): Rockville, Montg, Md	
24. FUNERAL DIRECTOR NAME: George R. Snowden	ADDRESS: 246 N. Washington St, Rockville, Md	25a. DATE REC'D. BY REGISTRAR: FEB 03 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 60M 7/84
(VRA 15, 4)

025350 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05498 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, air other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
EDWARD	H.	KOCH	2-18-89	4:45 P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
MALE	CAUCASIAN	MARCH 9 1916	72 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
WASHINGTON, DC	USA		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING	HOLY CROSS HOSPITAL	SUPERVISOR	DEPT OF NAVY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES ☐ NO ☒	10607 AMHERST AVENUE 20902

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
FREDERICK	J.	KOCH, SR.	ELLA	BARBARA	KLEIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	1944-1946	220-12-3255	DAUGHTER ALICE GREENWOOD	12175 MESA VERDE TRAIL JACKSONVILLE, FLA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) 32223

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) HEPATO-RENAL FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 5, 19 89, to Feb 18, 19 89, that (I) (~~we~~) last saw the deceased alive on Feb 18 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Bernard A. Fitzgerald MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
BERNARD A. FITZGERALD	211 UNIVERSITY BLVD E, SILVER SPRING, MD 20901

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	FEB 21, 1989	METROPOLITAN CREMATORY	ALEXANDRIA VA

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 22 '89	Julia Davidson-Randall

BP 10+1

DHMH - 1650M 1/81 (VRA 15, 4)

023459 FEB 22 89 11-8-89 cm

FOR STATE REGISTRAR Item:16b per Informant

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005497
REG. NO.

TO MEDICAL EXAMINER: CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)	FIRST Mary	MIDDLE C.	LAST Kopf	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐	MONTH Feb.	DAY 13	YEAR 1989	2b. HOUR 6 M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	Feb. 13	1989	6:32 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.

10. CITY OR TOWN OF DEATH Silver Spg.	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY Public

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN Silver Spg.	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS 8505 Springvale Rd.

14. FATHER'S NAME FIRST Harry	MIDDLE M.	LAST Chalfant	15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE	LAST FitzRandolph

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES) None	16b. 224-58-1469 578-50-5047	17. INFORMANT David H. Kopf ADDRESS 535 W. Eugenie Street Chicago, Ill. 60614

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Dist

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None

19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Dep. MEDICAL EXAMINER DATE SIGNED Feb 14 1989

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers M.D. ADDRESS 1919 Seminary Road Silver Spr. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE Feb. 15, 1989	23c. NAME OF CEMETERY OR CREMATORY George Washington	23d. LOCATION CITY OR TOWN Medical School	COUNTY Wash. D.C. STATE

24. FUNERAL DIRECTOR NAME Columbia Mortuary Services ADDRESS 225 Missouri Ave. NW. Washington D.C. 20011

25a. DATE REC'D. BY REGISTRAR FEB 21 1989

25b. REGISTRAR'S SIGNATURE Julia Davidson-Landeau

07-84 25M BP____

DHMH - 17 (VR A15 ME (5))

022321 FEB 089

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 05500

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Doris		Kostishak	February 7, 1989	7:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	July 19, 1932	56 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Penn.	USA		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Burtonsville	3013 Winifred Drive	Housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Mont.	Burtonsville	YES ☒ NO ☐	3013 Winifred Drive 20866

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George		Shuey	Zelma		Brosius

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A		207 26 0898	Michael Kostishak (Husband)	Same as 13E

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC COLON CANCER

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/24, 19 86, to 2/7, 19 89, that (I) (we) last saw the deceased alive on 1/23, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: Dennis A Priebat MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Dennis A. Priebat	110 Irving St.N.W. Wash.D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/10/89	Odd Fellows Cemetery	Frackville Penn.

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New	Hamp.Ave.S.S. Md.	FEB 09 1989	Julia Davidson Registrar

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

024146 FEB 29 89 1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055501 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other abnormal event, the medical examiner must be notified at once.

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Julie	MIDDLE: E.	LAST: Kovach	2a. DATE OF DEATH MONTH DAY YEAR: January 31 1989	2b. HOUR: 8:55 AM	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 4/ 09/ 28	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: Government		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 13810 Eastland Street 20853	
14. FATHER'S NAME FIRST: Stephen	MIDDLE:	LAST: Kosct	15. MOTHER'S MAIDEN NAME FIRST: Julia	MIDDLE:	LAST: Kucirka
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO: 127-20-7643	17. INFORMANT: Peter Kovach	ADDRESS: Same as #13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Arrest	30 min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Respir. Fury Failure	11 D.yl
DUE TO, OR AS A CONSEQUENCE OF (c)	Restrictive & obstructive Lung Disease	2 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Dec. 8, 19 87, to Jan. 31 19 89, that (I) (we) last saw the deceased alive on Jan. 30, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Frank Mayo,	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 1-31-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frank Mayo, M.D.	22e. ADDRESS: 16220 Frederick Rd. #213 Gaithersburg, MD 20877		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: FEB 4,89	23c. NAME OF CEMETERY OR CREMATORY: St. Nicholas Cem	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Aurelius, Cayuga, N.Y.	
24. FUNERAL DIRECTOR NAME: DeVol Funeral Home	ADDRESS: 10 E. Deer Park Dr. Gaithersburg, MD	25a. DATE REC'D BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

022101 FEB-89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR — REG. NO. 89 055502

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARGUERITE	MIDDLE: M.	LAST: Konkle	2a. DATE OF DEATH MONTH DAY YEAR: 2 4 89	2b. HOUR: 10:?? P.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: AUG. 2, 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MICHIGAN	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health CARE	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): BENEFIT INVESTIGATOR	12b. KIND OF BUSINESS OR INDUSTRY: COMMUNICATIONS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: MONT.	13c. CITY OR TOWN: GAITHERSBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS (INCL. ZIP CODE): 211 RUSSELL AVE. 20877
14. FATHER'S NAME FIRST: BENJAMIN	MIDDLE: -	LAST: MATTHEWS	15. MOTHER'S MAIDEN NAME FIRST: NORA	MIDDLE: - LAST: GREGG
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-14-4732	17. INFORMANT: MARYRUTH GIBLIN	6 ECONOMY CT. BALTIMORE, MD. 21204	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Atherosclerosis with chronic Brain Syndrome

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease with Hip Fracture

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 3-1 19 88 to 2-4 19 89, that (I) (we) last saw the deceased alive on 1-12 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John J. Fellelo MD FOR JAMES MOORE M.D. — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): TIBOR E. FREKKO MD

22e. ADDRESS: 19211 MONTGOMERY VILLAGE AVE

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: FEB. 6, 1989	23c. NAME OF CEMETERY OR CREMATORY: BALT. WASH. CREMATORY	23d. LOCATION CITY OR TOWN: LAUREL COUNTY: MONT. STATE: MD.

24. FUNERAL DIRECTOR NAME / ADDRESS: MURIEL H. BARBER LAYTONSVILLE, MD. 20879

25a. DATE REC'D. BY REGISTRAR: FEB 7 1989

25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

12326 FEB 21 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055 03 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: MARY MADELINE KRAFT			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 16 1989	2b. HOUR: 5:50 A M	
3. SEX: FEMALE	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 12 1930	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): OHIO	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: Anne Arundel	13c. CITY OR TOWN: GLEN BURNIE	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 7612 MARCY DRIVE 21061	
14. FATHER'S NAME FIRST MIDDLE LAST: SHERMAN E. LEWIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: MAUD L. NACE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): None	16b. SOCIAL SECURITY NO.: 285-22-6692	17. INFORMANT: (Son)	ADDRESS: 7612 Marcy Drive Mr. John R. Moody Glen Burnie, Md. 21061	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): WIDELY METASTATIC SQUAMOUS CELL CARCINOMA OF ESOPHAGUS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: THE

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 4 19 89 to FEBRUARY 16 19 89 that (I) (we) last saw the deceased alive on FEBRUARY 16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C.A. Thompson	DEGREE: MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 16 Feb 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): C.A.THOMPSON, LT, MC, USN	22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb 21,1989	23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Gardens	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Donnelsville, Clark, Ohio
24. FUNERAL DIRECTOR NAME: R. H. Hopkins	ADDRESS: Singleton Funeral Home Glen Burnie, Maryland	25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rhodes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

022440 FEB 1389

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055041 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining pages in envelope and forward with the remains. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation. Page 1 may be removed for bonding purposes.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, even if the traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Victoria	MIDDLE: I.	LAST: Kuser	2a. DATE OF DEATH MONTH DAY YEAR: February 01, 1989
2b. HOUR: 2:48p M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: September 13, 1903	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Minnesota	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govn'mt.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Brookeville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 23110 Georgia Avenue 20833			
14. FATHER'S NAME FIRST: Albert	MIDDLE: -	LAST: Kortoe	15. MOTHER'S MAIDEN NAME FIRST: Louise / MIDDLE: - / LAST: Flak
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): -	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 470-18-6464	17. INFORMANT: Kathleen Hutchins ADDRESS: 11706 S. Laurel Dr. Apt2D Laurel, Md. 20708

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Acute CVA

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 89 to 2/11 19 89, that (I) (we) last saw the deceased alive on 2/11 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/12/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Allan B. Cohan, M.D.

22e. ADDRESS: 13975 Connecticut Avenue Silver Spring, MD 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 6, 1989	23c. NAME OF CEMETERY OR CREMATORY: Parklawn	23d. LOCATION CITY OR TOWN: Rockville / COUNTY: Montgomery / STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Muriel H. Barber Funeral Home, Laytonsville, Md 20879	25a. DATE REC'D. BY REGISTRAR: FEB 6 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 1650M 1/81 (VRA 15, 4)

025375 MAR 16 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 055505

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit; then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: G..	LAST: Jalepes	2a. DATE OF DEATH MONTH DAY YEAR: Feb. 20, 1989	2b. HOUR: 10:35A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Mar. 15, 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Greece	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MOntgomery MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 14905 Emory Lane	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: own home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Mont	Rockville	YES ☐ NO ☐	14905 Emory Lane 20853

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
John / Economides	Katherine / Petrides	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A		579 54 4973	Athena Zieske (Daughter)	Same as 13E

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary arrest	1-2 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Congestive Heart failure	1-2 years
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary artery disease	10+ years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumonitis, Old multiple CVA, Osteoporosis, multiple Fx spine

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I **certify** that (I) (this hospital) attended the deceased from 2/13 19 89 to 2/20 19 89, that (I) (we) last saw the deceased alive on 2/13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Ruben Cosca	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2/25/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RUBEN C. COSCA M.D	17529 Redland Road, Derwood, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/22/89	Ft. Lincoln	Brentwood PG Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md	FEB 21 '89	Julia Davidson-Randall

025377 MAR 16 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055506
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial card. Then please remove carbonpapers. Pages 3 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 indicates injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
THETIS	O.	JOHNSON	Feb.	16,	1989	6:30P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	Jan.	31	1898	91 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Scotland	USA		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	Housewife	own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	308 Eldrid Drive 20904

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	Lorne	Furrie	Josephine	Hoffmeyer	Child

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A	N/A	219-36-8673	Olivia Dodge-daughter-	(same as 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gram negative Sepsis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24hr

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Arteriosclerotic cardiovascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-8-64 19__ to 2-16 19 89 that (I) (we) last saw the deceased alive on 2-16 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M Lenk	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MYRON L. LENKIN	2309 Shorefield Rd. Wheaton, Md. 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2-18-1989	Wash. National Cemetery	Suitland Pr. Georges Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home	11800 N.H. Ave. Sil. Spr. Md.	FEB 21 '89	Julia Davidson-Randall

3647 FEB 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055507 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Nancy Middle: R Last: Lakey (Nancy / Lakey)			2a. DATE OF DEATH Month: 2 Day: 13 Year: 89	2b. HOUR: 11:30 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month: 11 Day: 16 Year: 37	6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Software Analyst	12b. KIND OF BUSINESS OR INDUSTRY: Computer
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George's	13c. CITY OR TOWN: College Park	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 9208 Dewberry Lane / 20740
14. FATHER'S NAME First: Webster Middle: Last: Richardson			15. MOTHER'S MAIDEN NAME First: Sara Middle: Last: Schoene	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 226-50-6451	17. INFORMANT: Jerry A. Lakey,	ADDRESS: Same as 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	renal failure	one week
DUE TO, OR AS A CONSEQUENCE OF (b)	Septicemia	four weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	myelosuppression	four weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Small cell cancer of the lung

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from February 17, 19 69, to February 13, 19 89, that (I) (we) last saw the deceased alive on February 12, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Maryann A Voith MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-14-89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Maryann A-Voith MD	22e. ADDRESS: 5530 Wisconsin Ave #1240 Chevy Chase, MD 20815		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2-14-89	23c. NAME OF CEMETERY OR CREMATORY: Suburban Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME: Rapp Funeral Services, P. A. ADDRESS: 933 Gist Avenue, Silver Spring, MD 20910		25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 1650M 1/81 (VRA 15, 4)

025063 MAR - 9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 055508

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Theodore	Johnathan	Larabay	February 17, 1989	1:12pm
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
Male	Black/White 2	February 17, 1989	YRS.	1 / 50
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	USA		Montgomery	MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Shady Grove Adventist		N/A	N/A
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Frederick	Brunswick	YES ☒ NO ☐	618 Fifth Avenue 21716
14. FATHER'S NAME FIRST / MIDDLE / LAST			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Tarry James	Larabay		Deborah	Lynn Pray
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A		N/A	Deborah Larabay	618 Fifth Avenue Brunswick, MD 21716

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Extreme prematurity

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from February 17 19 89 to February 17 19 89, that (I) (we) last saw the deceased alive on February 17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
Robert Buczek	MD		2-17-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Robert Buczek, MD	9901 Medical Center Drive Rockville, Maryland 20850		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb. 17, 1989	Shady Grove Adventist	Rockville Montgomery MD
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
N/A		FEB 27 1989	Linda Gordon-Randall

024077 Feb 23

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055099 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Margaret	Naylor	Lauderdale	February 6, 1989	1:30P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Caucasian	March 6, 1903	85 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	United States		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Chevy Chase	3801 Williams Lane	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Chevy Chase	YES ☐ NO ☒	3801 Williams Lane/20815

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Henry		Naylor	Margaret		Meigs

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		578-54-1254	Henry N. Lauderdale, same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Cerebrovascular Emboli
DUE TO, OR AS A CONSEQUENCE OF (b) Atrial Fibrillation
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Hypertension, Chronic Obstructive Pulmonary Disease, Right & Left Heart Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 87, to Feb 6, 19 89, that (I) (we) last saw the deceased alive on Feb 4, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Carol W Garvey MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1989 February 6,

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Carol W. Garvey, M.D.	11510 Old Georgetown Road Rockville, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 8, 1989	Congressional Cemetery	Washington, D.C.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814	FEB 09'89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

B24133 FEB 29 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 055 10

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
THOMAS	A.	LAWRENCE, SR.	JANUARY 31, 1989	8:00A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	CAUCASIAN	APRIL 1 1921	67 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
NORTH CAROLINA	USA		MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
OLNEY	17331 BUEHLER ROAD	REGIONAL VICE-PRES MARRIOTT, INC	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	OLNEY	YES ☐ NO ☐	17331 BUEHLER ROAD 20832

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
THADDEUS		LAWRENCE	ALICE		PENDER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	WWII	245-14-8731	LOLETA W. LAWRENCE/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Prostate Cancer — 3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (this hospital) attended the deceased from 28 April 19 88 to 31 Jan 19 89, that (I) (we) last saw the deceased alive on 31 Jan 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BEMSINGER MD — 22e. ADDRESS 7825 Broadway (Ste Dr. Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 3, 1989	GATE OF HEAVEN CEM.	SILVER SPRING MONTGOMERY MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 03'89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 2071

DHMH - 16 50M 1/81 (VRA 15, 4)

023759 FEB 26 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055111
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ARCH	MIDDLE: WILLIAM	LAST: LAWSON JR.	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 17, 1989	2b. HOUR: 9:30 P M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: AUGUST 24, 1935	6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: GERMANTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 19515 FREDERICK ROAD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TRUCK MECHANIC	12b. KIND OF BUSINESS OR INDUSTRY: W.S.S.C		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: MONT.	13c. CITY OR TOWN: GERMANTOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 19515 FREDERICK ROAD 20874 Lot #201	
14. FATHER'S NAME FIRST: ARCH	MIDDLE: WILLIAM	LAST: LAWSON SR.	15. MOTHER'S MAIDEN NAME FIRST: LUCY	MIDDLE: -	LAST: HENSLEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): 1951 ?	16b. SOCIAL SECURITY NO.: 577-46-9031	17. INFORMANT: EUNICE L. LAWSON	ADDRESS: SAME AS #13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	5 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial Infarction	30 min
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Artery Disease	5 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Keith Lindgren	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/18/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Keith M. Lindgren, MD	22e. ADDRESS: 7600 Carroll Ave Takoma Pk MD. 20912		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 21, 1989	23c. NAME OF CEMETERY OR CREMATORY: LAYTONSVILLE	23d. LOCATION CITY OR TOWN: LAYTONSVILLE	COUNTY: MONT. STATE: MD.
24. FUNERAL DIRECTOR NAME: MURIEL H. BARBER	ADDRESS: LAYTONSVILLE, MD. 20879	25a. DATE REC'D. BY REGISTRAR: FEB 22 1989	25b. REGISTRAR'S SIGNATURE: Meridon Randall		

024096 FEB 2 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05512 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Ida MIDDLE E. LAST Leber

2a. DATE OF DEATH: MONTH DAY YEAR 2-7-89

2b. HOUR 9 A M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH DAY YEAR July 6, 1904

6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Collingswood Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Registered Nurse

12b. KIND OF BUSINESS OR INDUSTRY: Private Duty

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY:

13c. CITY OR TOWN: Baltimore

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS / ZIP CODE: 4368 Eldone Road/21229

14. FATHER'S NAME: FIRST James MIDDLE LAST Curtis, Sr.

15. MOTHER'S MAIDEN NAME: FIRST Anna MIDDLE LAST Fletcher

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 216-34-7680

17. INFORMANT: Wilma Leber Power

ADDRESS: 15208 Apricot Lane Gaithersburg, MD 20878

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1hr

DUE TO, OR AS A CONSEQUENCE OF (b): Acute CVA — 3 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2 19 89 to 2/7 19 89 that (I) (we) last saw the deceased alive on 2/6 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): R Bakyan

22e. ADDRESS: 15001 Outlet mill Rd Gaithersburg MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: February 10, 1989

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION: CITY OR TOWN Baltimore COUNTY STATE Maryland

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/Rockville, Inc.

ADDRESS: 300 West Montgomery Ave., Rockville, MD 20850

25a. DATE REC'D. BY REGISTRAR: FEB 09'89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 16 60M 7/84 (VRA 15, 4)

024150 FEB 29 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055 13 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Eleanore	MIDDLE	LAST: LEECH	2a. DATE OF DEATH MONTH DAY YEAR: February 4, 1989	2b. HOUR: 5:00 AM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 15, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., DC	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11 Primrose St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None	12b. KIND OF BUSINESS OR INDUSTRY: None

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Mont.	Chevy Chase	YES ☒ NO ☐	11 PrimroseSt. 20815

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Abner	Y	Leech, Jr.	Clara		Stowell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		578-05-0244	A Miss Marion Leech	Same as item # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Diabetes mellitus. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure. — years.

DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Pancreas

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1960 19___, to February 4, 1989, that (I) (we) last saw the deceased alive on January 30, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
David R. Lawrenz	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb. 4, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. David R. Lawrenz, M. D.	1145 19th Street, NW Washington, DC 20036

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-7-89	Glenwood Cem.	Wash., DC

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sosn, Inc.	5130 WI Ave. NW Wash., DC 20016	FEB 06 '89	Julia Davidson-Rondelle

023386 FEB 22 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055 14 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or decedent's physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROSA MIDDLE: S. LAST: LESTER			2a. DATE OF DEATH MONTH DAY YEAR: 1/29. Jan. 29-89
2b. HOUR: 4:05A.M.			
3. SEX: F	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 9 04 04	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: MONT. MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BOOKBINDER	12b. KIND OF BUSINESS OR INDUSTRY: FAWCETT/HAYNES

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	GAITHERSBURG	YES ☐ NO ☐	12 DALAMAR STREET #2 20877

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
GEORGE / STALLINGS	LULU / UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		225-03-5780	DAUGHTER P. VICTORIA JONES	3200 KAYSON STREET SILVER SPRING, MD 20906

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MULTIPLE CEREBRAL INFARCTS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MONTHS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): CEREBROVASCULAR INSUFFICIENCY — YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPERTENSIVE CARDIOVASCULAR DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/3 19 88 to 1/29 19 89, that (I) (we) last saw the deceased alive on 1/28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Martin Shapell	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1/29/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARTIN C. SHAPELL	3720 FARRAGUT AVE KENSINGTON MD — 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	JAN 30, 1989	METROPOLITAN CREMATORY	ALEXANDRIA VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 01 '89	Julia Davidson-Randall

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

023315 FEB 21 - 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055 15
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Helen / J. / Lennon	2a. DATE OF DEATH — MONTH DAY YEAR	Feb. 7, 1989	2b. HOUR: 1:15 AM
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH — MONTH DAY YEAR: Oct. 19, 1912
6. AGE (IN YEARS LAST BIRTHDAY)	76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Minn.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery MD.			
10. CITY OR TOWN OF DEATH	Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Bethesda Retirement & Nursing Ctr.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY	Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	None	13b. COUNTY	None	13c. CITY OR TOWN: Wash. D.C.
13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET ADDRESS / ZIP CODE	4619 Greene Place, N.W.	
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Edward / / Johnson	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Alma / Olivia / Anderson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no	(IF YES, GIVE WAR OR DATES)	---	16b. SOCIAL SECURITY NO.: 579-54-8858
17. INFORMANT — ADDRESS	Son - John E. Lennon - Same as #13			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Failure	48 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Pneumonia	10 Days
DUE TO, OR AS A CONSEQUENCE OF (c)	Parkinson Disease	10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Polymyalgia Rheumatica

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (1) (this hospital) attended the deceased from 8/15 19 88 to 2/7 19 88, that (I) (we) last saw the deceased alive on 2/6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: Feb.7, 1989
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas Havel, M.D.	22e. ADDRESS: 4201 Cathedral Ave., N.W, Wash. D.C.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Cremation	23b. DATE: Feb.7'89	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory	23d. LOCATION — CITY OR TOWN / COUNTY / STATE: Alexandria, Virginia
24. FUNERAL DIRECTOR — NAME / ADDRESS	DeVol Funeral Home, Washington, D.C.	25a. DATE REC'D. BY REGISTRAR: FEB 16 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

021837 FEB-6 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05516
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Donald	R.	Lesnick	February 1, 1989	6:55A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	10 - 22 - 31	57 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH		
OHIO	U.S.A.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Olney	Montgomery General Hospital	Elec. Engineer	U.S. Gov't.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Montgomery	Ashton	YES ☐ NO ☒	1110 Ashland Dr. 20861

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Andrew	P.	Lesnick	Helen		Bentz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	1955-1958	184-24-2118	XXXXXXXXXX David Lesnick	Same As#13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multi-Organ failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Sepsis,

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

Alcohol withdrawal syndrome, Cecal Volvulus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/16/89	Cecal Volvulus	YES ☐ NO ☒	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (this hospital) attended the deceased from 1/16/89, 19 89, to 2/1/89, 19 89, that I (we) last saw the deceased alive on 2/1/89, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Arthur F. Woodward	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-1-1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Arthur F. Woodward, M.D.	4000 Olney Laytonsville Rd. Olney, Md. 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-2-89	Metropolitan Crematory	Alexandria Fairfax VA.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donald V. Borgwardt	4400 Powder Mill Rd. Beltsville, Md. 20705	FEB 3 1989	Julia Davidson-Randall

DHMH - 1650M 1/81 (VRA 15, 4)

022441 FEB 13 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

REG. NO. 89 005517

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DOROTHY	MIDDLE	LAST: LESSER	2a. DATE OF DEATH MONTH: 2 DAY: 1 YEAR: 89	2b. HOUR: 3 P M	
3. SEX: F	4. RACE: W	5. DATE OF BIRTH MONTH: 3 DAY: 19 YEAR: 99	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Russia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerical Worker	12b. KIND OF BUSINESS OR INDUSTRY: Chemical Co.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Florida	13b. COUNTY: Broward	13c. CITY OR TOWN: Hallandale	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 2200 East Hallandale Blvd. #201	
14. FATHER'S NAME FIRST: Israel MIDDLE LAST: Berlin		15. MOTHER'S MAIDEN NAME FIRST: Lillian MIDDLE LAST: Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 087-05-8067	17. INFORMANT ADDRESS: Monroe Lesser 6011 Merryvale Ct. Springfield, Va. 22152		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIORESPIRATORY ARREST	5 MIN
DUE TO, OR AS A CONSEQUENCE OF (b)	ASPIRATION PNEUMONIA	4 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	CEREBROVASCULAR DISEASE	4 MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: ASHD, ATRIAL FIBRILLATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 12/5 19 88 to 2/1 19 89, that I (we) lost sight as a patient the deceased alive on 2/1 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Steven Lipson	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/1/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): STEVEN LIPSON	22e. ADDRESS: 6121 MONTROSE RD, ROCKVILLE		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/3/89	23c. NAME OF CEMETERY OR CREMATORY: Mt. Hebron Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Flushing, N.Y.
24. FUNERAL DIRECTOR NAME: Ives-Pearson Funeral Home ADDRESS: 472 N. Washington St., Falls Church, Va.	25a. DATE REC'D BY REGISTRAR: FEB 6 1989	25b. REGISTRAR'S SIGNATURE: Sicha Davidson-Randall	

DHMH - 16 50M 1/81 (VRA 15, 4)

024301 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055 13
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARTHA	MIDDLE:	LAST: LEV	2a. DATE OF DEATH MONTH DAY YEAR: 2-26-89	2b. HOUR: 9:35 AM	
3. SEX: Female	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: 9 15 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): POLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater WASH	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dressmaker	12b. KIND OF BUSINESS OR INDUSTRY: Clothing		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	MONT.	Rockville	YES ☒ NO ☐	6121 Montrose Road 20852

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Joseph / / LASHINSKY	UNKNOWN / / (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		052-09-9836	MRS. PAULA RUDIMAN	1103 Shadow Lake CR. MT. PLEASANT

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY ARREST	5 MIN
DUE TO, OR AS A CONSEQUENCE OF (b)	CONGESTIVE HEART FAILURE	2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)	HYPERTENSIVE HEART DISEASE	10 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PNEUMONITIS, DIABETES MELLITUS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (this hospital) attended the deceased from 10/29 19 81, to 2/26 19 89, that I (we) last saw the deceased alive on 2/26 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Steven Lipson	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/26/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
STEVEN LIPSON	6121 MONTROSE RD, ROCKVILLE

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/27/1989	Mount Lebanon	Hyattsville, P. G., Md.

24. FUNERAL DIRECTOR (NAME) / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.	MAR 1 - 1989	Gina Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 4/82 (VRA 15, 4)

022087 FEB-7 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05519 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Esther; MIDDLE: ; LAST: LEVIN			2a. DATE OF DEATH MONTH 2 DAY 5 YEAR 89	2b. HOUR 345 A.M.	
3. SEX: FEMALE	4. RACE: Caucasian	5. DATE OF BIRTH MONTH 8 DAY 20 YEAR 16	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES [X] NO [ ]	12712 Epping Terrace (20906)

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
William / / Levin	Leah / / Pollack	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): -------	16b. SOCIAL SECURITY NO.: 085-03-8880
17. INFORMANT: William Levin;Husband;	ADDRESS: 12712 Epping Terrace; Silver Spring, Md. 20906	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 WEEK
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): CHRONIC OBSTRUCTIVE LUNG DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/7/88 to 2/5/89, that (I) (we) last saw the deceased alive on 2/5/89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
[signature]	M.D.	ATTENDING PHYSICIAN [ ]	MEDICAL DIRECTOR [ ]	STAFF PHYSICIAN [X]	2/5/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): D.D. PATEL	22e. ADDRESS: 6121 MONTROSE RD ROCKVILLE MD				

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/7/89	King David Mem. Garden	Falls Church; Fairfax; Va.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	FEB 7 1989	[signature] Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

022947 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055520
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALEX	MIDDLE	LAST: LEVINE	2a. DATE OF DEATH MONTH DAY YEAR: February 8, 1989	2b. HOUR: 3:35a.m.
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: November 9, 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 9414 Fern Hollow Way (20879)
14. FATHER'S NAME FIRST: Harry	MIDDLE	LAST: Levine	15. MOTHER'S MAIDEN NAME FIRST: Henrietta	MIDDLE	LAST: Silverman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): - - - - - - -	16b. SOCIAL SECURITY NO.: 579-28-1438	17. INFORMANT: Suzanne Kahn; Daughter;	ADDRESS: 9414 Fern Hollow Way; Gaithersburg, Md. 20879	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest.	
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Renal Failure.	2 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Acute Hepatic Failure	2 days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-5 19 89 to 2-8 19 89, that (I) (we) last saw the deceased alive on 2-8 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Loreto S. Albiol	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-8-89.
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LORETO S. ALBIOL.		22e. ADDRESS: 6121 MONTROSE RD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/10/89	23c. NAME OF CEMETERY OR CREMATORY: Eternal Light Mem. Gardens;	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Boynton Beach, Florida	
24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS	ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852	25a. DATE REC'D. BY REGISTRAR: FEB 13 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

023312 FEB 12 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005521

1. DECEASED NAME (TYPE OR PRINT): FIRST ALEX MIDDLE LAST LIEBENSON

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 2 DAY 13 YEAR 19 89 — 2b. HOUR 7:49 P M

3. SEX: male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 6 DAY 11 YEAR 22 — 6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 13 YEAR 19 89 — 2d. HOUR 7:49 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK

7b. CITIZEN OF WHAT COUNTRY? U. S. A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): AUDITOR

12b. KIND OF BUSINESS OR INDUSTRY: NASSA

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: MONTGOMERY — 13c. CITY OR TOWN: POTOMAC — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 8618 BUNNELL DRIVE 20854

14. FATHER'S NAME: FIRST SIDNEY MIDDLE LAST LIEBENSON

15. MOTHER'S MAIDEN NAME: FIRST IDA MIDDLE LAST HOROWITZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 088 12 7340

17. INFORMANT: HARLEY B. LIEBENSON, ADDRESS: 8618 BUNNELL DRIVE POTOMAC, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Arrest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Alzheimers disease.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒ XX

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Taubes M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-14-89

EXAMINER'S NAME (TYPE OR PRINT): John Taubes ADDRESS: 8218 Wisconsin Bethesda Ave

23a. BURIAL, CREMATION, REMOVAL: BURIAL — 23b. DATE: 2/15/1989 — 23c. NAME OF CEMETERY OR CREMATORY: MOUNT LEBANON CEMETERY — 23d. LOCATION CITY OR TOWN: ADELPHI, COUNTY: PR. GEO., STATE: MARYLAND

24. NAME OF FUNERAL DIRECTOR: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME — ADDRESS: 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR: FEB 16 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

02528-7 MAR 14 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05522 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: William	MIDDLE: Abner	LAST: Linthicum,Jr.	2a. DATE OF DEATH MONTH DAY YEAR: February 12, 1989	2b. HOUR: 11:15am	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 3, 1929	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 529 Anderson Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Attorney	12b. KIND OF BUSINESS OR INDUSTRY: Law		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 529 Anderson Avenue/ 20850	
14. FATHER'S NAME FIRST: William	MIDDLE: A.	LAST: Linthicum	15. MOTHER'S MAIDEN NAME FIRST: Sue	MIDDLE: Sollers	LAST: Somervell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Korean	16b. SOCIAL SECURITY NO.: 215 38 3625	17 INFORMANT ADDRESS: Joyce W. Linthicum, wife, see #13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Malignant Lymphoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 Months
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from XXXXX May 19 88 to 2 712 19 89, that (I) XXXX last saw the deceased alive on XXXXXXXXX 1/19 19 89, and that in (my) XXX opinion death occurred on the date and hour and from the causes stated above, (I) XXXXXXXXX view the body after death.

22b. SIGNATURE: Jules R. Lodish, MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: Feb. 15,1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jules R. Lodish, M.D.
22e. ADDRESS: 2901 Olney-Sandy Spring Rd., Olney,Md. 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb.16,1989	23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery	23d. LOCATION CITY OR TOWN: Rockville,	COUNTY / STATE: Maryland
24. FUNERAL DIRECTOR (NAME / ADDRESS): Robert A. Pumphrey Funeral Home-Rockville, Inc. 300 West Montgomery Avenue, Rockville, Md. 20850	25a. DATE REC'D. BY REGISTRAR: FEB 16'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 15+1 photos

DHMH - 16 50M 1/81 (VRA 15, 4)

022100 FEB -9 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 055523

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARIE	MIDDLE: P.	LAST: LINTON	2a. DATE OF DEATH MONTH: FEBRUARY	DAY: 1,	YEAR: 1989
2b. HOUR: 9:25 P M					
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: NOV. DAY: 29 YEAR: 1891	6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:
IF UNDER 24 HRS HOURS:	MIN.:				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: BROOKEVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 18 HIGH ST. 20833	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Brookeville	YES ☒ NO ☐	18 High Street 20833

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Frank	–	Panuska	Anna	–	Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
–		218-05-0080	Florence Johnston, same as #13e.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease — 4-5 years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Sick Sinus Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from August, 19 88, to 2/1, 19 89, that (I) ~~(we)~~ last saw the deceased alive on 1/4, 19 88, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Jules R. Lodish,	M.D.	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jules R. Lodish	2901 Olney-Sandy Spring Rd Olney Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb. 4, 1989	St. John's	Olney	Mont.	Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Muriel H. Barber Funeral Home, Laytonsville, Md. 20879	FEB 7 1989	Gloria Davidson-Pendere

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 REG. NO. 005524

024112 FEB 29 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ANGIOLINA — MIDDLE: — LAST: LISIEWICZ

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☐ — MONTH: 2 — DAY: 1 — YEAR: 1989

2b. HOUR: 450 PM

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH: 5 — DAY: 13 — YEAR: 24

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. — IF UNDER 1 YR. MONTHS: — DAYS: — IF UNDER 24 HRS. HOURS: — MIN.:

2c. DATE PRONOUNCED DEAD — MONTH: 2 — DAY: 1 — YEAR: 1989

2d. HOUR: 450 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Italy

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co., MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant

12b. KIND OF BUSINESS OR INDUSTRY: Advertising

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Wheaton

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 2614 Weisman Road/20902

14. FATHER'S NAME — FIRST: Pietro — MIDDLE: — LAST: Ramasco Volpon

15. MOTHER'S MAIDEN NAME — FIRST: Margherita — MIDDLE: — LAST: Boley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 220-58-8270

17. INFORMANT: Michael Craig — ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Respiratory Arrest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Tauber — M.D. — TITLE (SPECIFY): MEDICAL EXAMINER — DATE SIGNED: 2-1-89

EXAMINER'S NAME (TYPE OR PRINT): John Tauber — ADDRESS: 8218 Wisconsin Ave Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: February 3, 1989

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d. LOCATION CITY OR TOWN: Silver Spring — COUNTY — STATE: Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR: FEB 06 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M — BP X — DHMH - 17 (VR A15 ME (5))

024468 MAR-289

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89-05525

1. DECEASED NAME (TYPE OR PRINT) FIRST: RUBIN	MIDDLE: ROBERT	LAST: LOBEL	2a. DATE OF DEATH MONTH DAY YEAR: 2 21 89	2b. HOUR: 320 A M	
3. SEX: MALE	4. RACE: CAUC	5. DATE OF BIRTH MONTH DAY YEAR: 5 29 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEWYORK	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MANOR CARE WHEATON	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALESMAN	12b. KIND OF BUSINESS OR INDUSTRY:		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
California		Hayward	YES ☒ NO ☐	28265 Beatron Way 99999

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Morris / / Lobel	/ / Barnett	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT / ADDRESS**
No	061-05-1079	Richard Lobel Briar Dale Rd. Durwood, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) DEMENTIA, PERIPHERAL NEUROPATHY - UNKNOWN ETIOLOGY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3YRS.

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

(1) RECURRENT ASPIRATION (2) CHRONIC ANEMIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from — 19 87, to 2-21 19 89, that (I) (we) last saw the deceased alive on 2-7 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	22c. DATE SIGNED
Marlene T. Hayman MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-21-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	**22e. ADDRESS**
MARLENE T. HAYMAN	501 N. FREDERICK RD. GAITHERSBURG, MD. 20877

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-24-89	Chapel of the Chimes	Hayward / / California

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Pumphry Funeral Home Bethesda Md	FEB 28 1989	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health & Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

999999

DHMH - 16 50M 4/82 (VRA 15, 4)

025176 MAR 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005526
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Isidore, MIDDLE: F., LAST: Lo Casio				2a. DATE OF DEATH MONTH DAY YEAR: January 22 1989	2b. HOUR: 8:50 pm
3. SEX: Male	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 9 22 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY		MD.
10. CITY OR TOWN OF DEATH: Rockville, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PAINTER	12b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
N.J.	BERGEN	RIDGEFIELD	YES ☒ NO ☐	342 SHALER BLVD. 99999

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
VITO / LO-CASCIO	CARMALLA / MONASTERO

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	150-07-2126	Wm LO CASCIO	297 BOWDEN RD CEDAR GROVE - N.J.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b): CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 11/25, 19 89, to 1/22, 19 89, that (I) ~~(we)~~ last saw the deceased alive on 1/17, 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Alan J. Chanales	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ALAN CHANALES	15225 SHADY GROVE RD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	1-26-89	MT. CARMEL	TENAFOY BERGEN N.J.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W.D. HILTON	22111 BEALLSVILLE RD BARNESVILLE, MD.	JAN 27 1989	Gisha Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

BP 6

DHMH - 16 60M 7/84 (VRA 15-4)

0249.87 MAR -8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 05527
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Ethel	F.	Loewer	2-10-89	2215 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	03 06 02	86 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Ohio	U.S.A.		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Adventist Hospital	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	PG	College Park	YES ☒ NO ☐	5028 Iroquois Street 20740

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ransome	E.	Simkins	Rhoda	M.	Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		302-16-7328	Mary White	5028 Iroquois Street College Park, MD 20740

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-4-, 19 89 to 2-10-, 19 89, that (I) (we) last saw the deceased alive on 2-10-, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Clifford Chaudhry MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-11-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
M. H. CHAUDHRY, MD	14201 Laurel Park Drive #600 Laurel Md, 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/14/89	Maryland National	Laurel PG Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, PA	4739 Baltimore Ave., Hyattsville, MD 20781	FEB 17 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024820 MAR-7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055233
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: JIMMIE EUGENE LOHR				2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 28 1989	2b. HOUR: 8:27 P M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JUNE 25 1938	6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS.	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: U.S.NAVY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: PRINCE GEO'S	13c. CITY OR TOWN: RIVERDALE	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS: 6024 MUSTANG DRIVE 20184	
14. FATHER'S NAME FIRST MIDDLE LAST: GEORGE WELDON LOHR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: GUSSIE MEREDITH HUNT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): 1956-1976	16b. SOCIAL SECURITY NO.: 232-58-8706		17. INFORMANT ADDRESS: GRACE V. LOHR, 6024 MUSTANG DRIVE, RIVERDALE, MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (~~X~~ ~~X~~) attended the deceased from FEBRUARY 26 19 89 to FEBRUARY 28 19 89, that (I) (We) last saw the deceased alive on FEBRUARY 28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 1 MAR 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J.A.BUTLER, LCDR, MC, USN	22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: MAR.6,1989	23c. NAME OF CEMETERY OR CREMATORY: HALCYON HILLS CEMETERY	23d. LOCATION CITY OR TOWN: WHEELING COUNTY: WEST VIRGI
24. FUNERAL DIRECTOR NAME: IVES-PEARSON FUNERAL HOMES	ADDRESS: ARLINGTON, VA. 201	25a. DATE REC'D. BY REGISTRAR: MAR 3 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 1650M 1/81 (VRA 15, 4)

025142 MAR 12 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055299 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
JOSEPH	E.	LONG	2	04	89	6:30 am/M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
MALE	CAUCASIAN	2	06	08	81 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
ROCKVILLE	POTOMAC VALLEY NURSING CENTER	RETIRED	Auto Sales General Motors

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	ROCKVILLE	YES ☒ NO ☐	1688 E. GUDE DRIVE 20850

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Timothy	J.	Long	Catherine		Dugan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	--------	179-07-6737	Timothy J. Long (son)	Corinth, Texas 96205 3311 Fairview Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-respiratory Arrest	20'
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Thrombosis	24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic C-V. Disease	10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

C.O.P.D.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/3/ 19 82, to 2/5/ 19 89, that (I) (we) last saw the deceased alive on 2/2/ 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Stephen N. Jones MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Stephen N. Jones	809 Viers Mill Road Rockville, Md. 20851

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/7/89	Gate of Heaven Cemetery	Silver Spring,		Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home, Inc.	1331 Rockville Pike Rockville, Maryland 20852	FEB 08 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certicate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

023393 FEB 2 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055530
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
WALT	W.	LONG	JANUARY 29, 1989	5:30 am	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
MALE	CAUCASIAN	DEC 10, 1898	90 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
PENNSYLVANIA	U.S.A.		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
ROCKVILLE	199 ROLLINS DR. #427	FOREMAN	FURNITURE		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	ROCKVILLE	YES XX NO ☐	199 ROLLINS AV. #427 20852

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
NOT	AVAILABLE	LONG	AGNES	NOT	AVAILABLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	— — —	577-07-6549A	ELIZABETH B. LONG,	199 ROLLINS AV., ROCKVILLE, MD 20852

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	12 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Obstructive Pulmonary Disease	10-15 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arterio-sclerotic heart disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1 Jan, 19 68, to 29 Jan, 19 89, that (I) (we) last saw the deceased alive on 16 Jan, 19 89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Paul T. Noone	MD	ATTENDING PHYSICIAN ☑	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	29 Jan 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Paul T. Noone	50 Edmonston Drive Rockville, Maryland 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	FEB 2, 1989	MT. COMFORT CREMATORY	ALEXANDRIA, ALEXANDRIA, VA

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
TYSON WHEELER FUNERAL HOME, INC. 1331 Rockville Pike, Rockville, MD 20852	JAN 31 '89	Julia Davidson-Randall

BP 4

DHMH - 16 50M 4/82
(VRA 15, 4)

025282 MAR 1, 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05531
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified after.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Catherine	MIDDLE: E	LAST: Looney	2a. DATE OF DEATH MONTH DAY YEAR: 2 15 89	2b. HOUR: 620P M	
3. SEX: FEMALE	4. RACE: CAUC	5. DATE OF BIRTH MONTH DAY YEAR: 10 31 11	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: Potomac, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MANOR CARE POTOMAC	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NURSE	12b. KIND OF BUSINESS OR INDUSTRY: WORLD BANK		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: PR GEORGES	13c. CITY OR TOWN: HYATTSVILLE	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: 6105 42ND AVENUE #C201 20781	
14. FATHER'S NAME FIRST / MIDDLE / LAST: JEREMIAH LOONEY			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: HANNAH FLYNN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 579-44-6778	17. INFORMANT: TIM LOONEY	NEPHEW	ADDRESS: 3535 NORTHSHIRE LN BOWIE, MD 20716	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAL ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	SEPSIS	
DUE TO, OR AS A CONSEQUENCE OF (c)	CEREBROVASCULAR Accident	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (the hospital) attended the deceased from 1-19 19 89 to 2-15 19 89, that (I) (we) last saw the deceased alive on 2-15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Philip Silwartz MD DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-15-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Philip Silwartz

22e. ADDRESS: 15225 Shady Grove Rd #206 Rockville, MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 18, 1989	23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: SILVER SPRING MONTGOMERY MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 17'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 4

DHMH - 16 60M 7/84
(VRA 15, 4)

024155 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055532
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 3 and the above carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unnatural event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROBERT	MIDDLE: M	LAST: LORD	2a. DATE OF DEATH MONTH: 01	DAY: 28	YEAR: 89
2b. HOUR: 1145 am					
3. SEX: M	4. RACE: C	5. DATE OF BIRTH MONTH: 10	DAY: 6	YEAR: 17	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): AIRCRAFT MECH	12b. KIND OF BUSINESS OR INDUSTRY: DC AIR NATL GUARD		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: MONTG	13c. CITY OR TOWN: Kensington	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 11314 Woodson Ave 20895	
14. FATHER'S NAME FIRST: JAY	MIDDLE: B.	LAST: LORD	15. MOTHER'S MAIDEN NAME FIRST: GERALDINE	MIDDLE	LAST: WOLFE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): 1941-1945	16b. SOCIAL SECURITY NO: 180-03-0959	17. INFORMANT ADDRESS: ANNE C. LORD/WIFE/SAME AS 13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial infarction with Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD - Right Hemiparesis
DUE TO, OR AS A CONSEQUENCE OF (c): Cerebral emboli
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 82 to 1/28 19 89, that (I) (we) last saw the deceased alive on 1/28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D. DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT J. CERELLI
22e. ADDRESS: 4410 74th Ave Landover Hills MD 20784

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 1, 1989	23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: BRENTWOOD PR GEORGES MD
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

5 reside BP 2071

DHMH - 16 60M 7/84
(VRA 15, 4)

023134 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05533 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. Rogers, M.E. Notified & Released

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Mabel	MIDDLE: L.	LAST: Lucas	
2a. DATE OF DEATH	MONTH DAY YEAR: February 11, 1989		2b. HOUR: 12:05 P M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH: July 19, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., D. C.	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 7408 Carroll Ave., 20912	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Fed. Govt.,	12b. KIND OF BUSINESS OR INDUSTRY: G.O.P.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Mont.	Takoma Park	YES ☒ NO ☐	7408 Carroll Ave., 20912

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST: Arthur	MIDDLE: L.	LAST: Lucas	FIRST: Joel Etta	MIDDLE:	LAST: Layton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-38-4735	Florence Edwards-Florida	108 Laguna Blvd. Jacksonville Beach,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia	3 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebrovascular disease	10 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized arteriosclerosis	20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 8/3, 19 88, to 10/3, 19 88, that (I) (saw) lost saw the deceased alive on 10/3, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (saw) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Marvin Wadler	MD	☒ ☐ ☐	2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARVIN WADLER	8218 Wisc. Av. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/14.89	B/W Crematory	Laurel, P. G. Co., Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Takoma Funeral Home	254 Carroll St. NW, Washington, D. C.	FEB 15 1989	

BP

DHMH - 1650M 1/81
(VRA 15, 4)

022948 FEB 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 055334

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Leonard	MIDDLE: J.	LAST: Lurie	2a. DATE OF DEATH MONTH DAY YEAR: February 9, 1989	2b. HOUR: 6:35 P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 8, 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR MONTHS / DAYS:	IF UNDER 24 HRS. HOURS / MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1719 Ladd Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bureau Director	12b. KIND OF BUSINESS OR INDUSTRY: Dept. of Labor		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Wheaton	YES [ ] NO [X]	1719 Ladd Street / 20902

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Isser		Lurie	Zelda		Cashdan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW II	083-09-1156	Esther H. Lurie, Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ~~Pneumonia~~ Lung Cancer - Poorly differentiated — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [XX]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from January 19 79 to February 9 19 89, that (I) (we) last saw the deceased alive on February 6, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	Feb. 10, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jeffrey Drobis, M. D.	10810 Connecticut Avenue Kensington, MD 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-10-89	Suburban Crematory	Silver Spring, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rapp Funeral Services, P. A. 933 Gist avenue, Silver Spring, MD 20910	FEB 13 1989	Julia Davidson-Randall

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

023391 FEB 2 1 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005535
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Ennio MIDDLE: D LAST: Luzzi				2a. DATE OF DEATH MONTH DAY YEAR: Jan. 29, 89	2b. HOUR: 6:40 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 23, 1895		6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS.	IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Sicily	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Potomac Valley Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Tailor	12b. KIND OF BUSINESS OR INDUSTRY: Clothing
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 203 Mt. Vernon Place 20852	
14. FATHER'S NAME FIRST: Vincenzo MIDDLE: LAST: Rizzo				15. MOTHER'S MAIDEN NAME FIRST: Maria MIDDLE: LAST: Gregorio	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ----	16b. SOCIAL SECURITY NO.: 104-05-8991		17. INFORMANT ADDRESS: Inez R. Luzzi (daughter) same as 13e	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	12 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Pneumonia	4 days
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Arteriosclerotic Heart Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 Dec 19 88 to 29 Jan 19 89, that (I) (we) last saw the deceased alive on 29 Jan 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul T. Noone DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 29 Jan 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Paul T. Noone

22e. ADDRESS: 50 Edmonston Dr. Rockville, Md. 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 1/31/89	23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Cremation	23d. LOCATION CITY OR TOWN COUNTY STATE: Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS: Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR: JAN 31 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

122942 FEB 16 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055536
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Sally	MIDDLE	LAST: Lyons	2a. DATE OF DEATH MONTH DAY YEAR: 02 05 89	2b. HOUR: 1830 P M	
3. SEX: F	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: 01 29 13	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): SC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HomeMAKER	12b. KIND OF BUSINESS OR INDUSTRY: PVT Ind.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Montgomery	Silver Spring	YES ☒ NO ☐	1008 Wisconsin Ave 20903

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
John R Parker	Mackanna Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		409-38-9591	Saunda A E. Woodard, DAU.	1008 W. Wisconsin Ave SSM 20903

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Circulatory failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ischemic bowel disease

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized arteriosclerosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): upper GI bleeding, infarction of Colon Stroke, Seizure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 5 19 89, to Feb 1 19 89, that (I) (we) last saw the deceased alive on Feb 5 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Tung P Lee MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
TUNG P LEE MD	2411 Rigge Rd Hyattsville MD 20783

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	11 Feb 89	Ft Lincoln	Brentwood MD

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Johnson & Jenkins Inc	Washington DC	FEB 13 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024168 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05537 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have cards prepared. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Andrew	H.	MacIntire	February 4, 1989	1:30 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	February 24, 1917	71 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	United States		Montgomery County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban Hospital	Architect	Self-Employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES [ ] NO [X]	7000 Bradley Blvd./20817

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Andrew	H.	MacIntire	Emily		Clark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	178-07-7239	Mary MacIntire, same as #13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART II(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [XX]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/3 19 89 to 2/4 19 89 that (I) (we) last saw the deceased alive on 2/3 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Mark F Weinstein MD	ATTENDING PHYSICIAN [XX] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	Feb. 4, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Mark F. Weinstein, M.D.	11125 Rockville Pike, Rockville, Maryland 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb.7, 1989	Ft. Lincoln Cemetery	Brentwood, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25. DATE REC'D BY REGISTRAR	25. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, MD 20850	FEB 06 89	Julia Davidson-Randall

BP 101

DHMH - 16 50M 1/81 (VRA 15, 4)

022558 FEB 10 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005538
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and mailed to the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
SAMUEL		MAGAZINE	2	8	89 / 858 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
M	Caucasian	12	09	10	78 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Massachusetts	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery . MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery Gen. Hospital	Builder	Developing Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	Montgomery	Silver Spring	YES [X] NO [ ]	15115 INTERLACHEN DR. 20906

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William		Magazine	Ida		Feldman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	578-16-1924	Mildred Magazine	15115 Interlachen Dr.#307 Silver Spring, Md. 20906

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ruptured Abdominal Aortic Aneurysm — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2-8-89	Ruptured abd. Aortic Aneurysm	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 2-8, 19 89, to 2-8, 19 89, that (I) ~~(we)~~ last saw the deceased alive on 2-8, 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Michael Sulkin	[X] [ ] [ ]	2-8-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR MICHAEL SULKIN	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/10/89	King David Mem. Gdns.	Falls Church, Va.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ives-Pearson Funeral Home 472 N. Washington St., Falls Church, Va.	FEB 10 1989	Julia Pearson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

0234333 FEB 29 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 39 005539

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: C.	LAST: Manion	2a. DATE OF DEATH MONTH DAY YEAR: 02-20-89	2b. HOUR: 0311 M	
3. SEX: M	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 05-28-02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Unknown	12b. KIND OF BUSINESS OR INDUSTRY: Unknown		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George	13c. CITY OR TOWN: District Hgts	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 6006 Parkland Court 20747	
14. FATHER'S NAME FIRST: Unknown	MIDDLE	LAST: Unknown	15. MOTHER'S MAIDEN NAME FIRST: Unknown	MIDDLE	LAST: Unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 186-09-6979	17. INFORMANT: Ann Denovo	ADDRESS: 8701 Georgia Ave. Silver Spring, Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary artherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Bilateral Bronchopneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-6, 1989 to 2-20, 1989, that (I) (we) last saw the deceased alive on 2-13-, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was not) (did) (did not) view the body after death.

22b. SIGNATURE: John Tauber	DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-20-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Tauber	22e. ADDRESS: 8218 Wisconsin Ave Bethesda md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/23/89	23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Clinton P. G. Maryland	
24. FUNERAL DIRECTOR NAME: George P. Kalas Funeral Home	ADDRESS: 6160 Oxon Hill Rd. Oxon Hill, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 28 1989	25b. REGISTRAR'S SIGNATURE: [signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

021935 FEB 3-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05540
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the state. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Margaret / J. / Markwell	2a. DATE OF DEATH MONTH / DAY / YEAR	02 / 02 / 89	2b. HOUR	9:25 P M
3. SEX	Female	4. RACE	white	5. DATE OF BIRTH MONTH / DAY / YEAR	04 / 13 / 07
6. AGE (IN YEARS LAST BIRTHDAY)	81 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Illinois	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery MD.				
10. CITY OR TOWN OF DEATH	Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Colonial Villa Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired
12b. KIND OF BUSINESS OR INDUSTRY	Clerical				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	10005 Big Rock Rd. 20901

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Gustav / Kluhe	Marguerite / Ernst

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
N/A	N/A	330-07-7622	Joan M. Piper-daughter- (same as 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) IPF — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Months
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Alzheimers Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/4, 19 85, to 2/2, 19 89, that (I) (we) last saw the deceased alive on 2/2, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Michael E. Leibowitz, MD	11120 N.H. Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-3-1989	Metropolitan Crematory	Alexandria / Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home	11800 N.H. Ave. Silver Spring, Md.	FEB 6 1989	[illegible] Anderson-Randall

024072 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO 05541

1. DECEASED NAME (TYPE OR PRINT): FIRST ADA; MIDDLE M.; LAST MARTIN

2a. DATE OF DEATH: MONTH FEB. DAY 8 YEAR 1989

2b. HOUR: 6:30 pm

3. SEX: FEMALE

4. RACE: BLACK

5. DATE OF BIRTH: MONTH 10 DAY 17 YEAR 23

6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: Private

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: District of Columbia

13b. COUNTY

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 1313 22nd Street, N.W.

14. FATHER'S NAME: FIRST Harrison; MIDDLE; LAST Myers

15. MOTHER'S MAIDEN NAME: FIRST Daisy; MIDDLE; LAST Jordon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 579-44-7122

17. INFORMANT: Cathleen Foddrell ADDRESS: 8133 15th Ave., Hyattsville, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): INTRACEREBRAL Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: NONE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) this hospital) attended the deceased from Feb 7, 19 89, to Feb 8, 19 89, that (I) (we) last saw the deceased alive on Feb 8, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Zachary Simmons — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ZACHARY SIMMONS, MD

22e. ADDRESS: 7500 HANOVER PKWY, GREENBELT, MD 20770

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: February 13, 1989

23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial

23d. LOCATION: CITY OR TOWN Suitland; COUNTY Maryland; STATE

24. FUNERAL DIRECTOR: NAME John T. Stewart III; ADDRESS 4901 Benning Road, N.E. Stewart Funeral Home Washington, D.C.

25a. DATE REC'D. BY REGISTRAR: FEB 15 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

1022299 FEB 10 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05542
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Mary	Elizibeth	Martin	February 3, 1989	7:24 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	Black	August 15 1936	52 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
			Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	NIH, The Clinical Center		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Virginia		Lynchburg	YES [ ] NO [ ]	13 Victoria Ave. 20504

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	227-50-3733	Mr. O. B. Martin, husband same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY arrest	5 Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Teratomyosarcoma c metabolic encephalopathy	2 years
DUE TO, OR AS A CONSEQUENCE OF (c)	CONFUSION	1 wk

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Hypoglycemia, Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from January 18 19 89 to February 3 19 89, that (I) (we) last saw the deceased alive on February 3 19 89, and that to the best of my (our) knowledge death occurred on the date and hour and from the causes stated above. (I) (we) did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED
James Lynch	MD		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JAMES LYNCH	National Institutes of Health, 9000 Rockville Pike, Bethesda, Md. 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
2-8-89		FOREST HILL	LYNCHBURG VA.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John T. Rhuer Co Funeral Home 3015 12th Street Phone	FEB 7 1989	M. Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

022095 FEB 9-85

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WILLIS FRANKLIN MATTHEWS
REG. NO 0055

1. DECEASED NAME (TYPE OR PRINT): First Willis Middle Franklin Last Matthews
2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ Month Feb Day 6 Year 1989
2b. HOUR 7:45 AM ☐ PM ☑
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: Month January Day 25 Year 31
6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS.
IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN
2c. DATE PRONOUNCED DEAD: Month Feb Day 6 Year 1989 2:45 AM ☐ PM ☑
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON DC
7b. CITIZEN OF WHAT COUNTRY? U.S.A
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spg
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 700 Silver Ave. Apt 202
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CLAIMS ADJUSTR
12b. KIND OF BUSINESS OR INDUSTRY: INSURANCE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Mont.
13c. CITY OR TOWN: Silver Spg
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 700 Silver Ave Apt. 202

14. FATHER'S NAME: First EARL Middle S Last MATTHEWS
15. MOTHER'S MAIDEN NAME: First MARJORIE Middle — Last BUTLER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 579-40-6539
17. INFORMANT: JOHN B. LALLANDE ADDRESS: RT. 2, BOX 300 CHARLOTTE HALL MD

MEDICAL CERTIFICATION

19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) — (b) Yrs. — (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers, M.D. TITLE (SPECIFY): Dep^y MEDICAL EXAMINER
DATE SIGNED: Feb. 6, 1989
EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers ADDRESS: 1919 Seminary Rd., S.S., Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION
23b. DATE: FEB. 7. 1989
23c. NAME OF CEMETERY OR CREMATORY: Baltimore/Washington Crematory
23d. LOCATION CITY OR TOWN: Laurel COUNTY STATE: MD
24. FUNERAL DIRECTOR: Arthur Walters ADDRESS: Takoma Funeral Home 254 Carroll St. N. W. D. C.
25a. DATE REC'D. BY REGISTRAR: FEB 7 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson Bondeson

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP
DHMH - 17 (VR A15 ME (5))

023380 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05544
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — First: JOAN Joan — Middle: WALSH — Last: MAYMON

2a. DATE OF DEATH — Month: 01 — Day: 28 — Year: 89

2b. HOUR: 6 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — Month: 03 — Day: 23 — Year: 24

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: 8709 Fallen Oak DR. Bethesda, Md 20817

14. FATHER'S NAME — First: Walter — Middle: V. — Last: Walsh

15. MOTHER'S MAIDEN NAME — First: Elizabeth — Last: (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): ---

16b. SOCIAL SECURITY NO.: 081 22 3947

17. INFORMANT — ADDRESS: Paul Maymon, Same address as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic breast cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from early 1987 to June 1987, that (I) (we) last saw the deceased alive on June 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: David Satinsky — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAVID SATINSKY

22e. ADDRESS: 9715 Medical Center Dr, Rockville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/1/89

23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crem.

23d. LOCATION — CITY OR TOWN: Alexandria — COUNTY — STATE: VA

24. FUNERAL DIRECTOR — NAME: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisconsin Ave, NW, Wash., D.C. 20016

25a. DATE REC'D. BY REGISTRAR: FEB 02 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

RELEASED BY M.E.

P

BP 24

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or items 18 show any injury, or other traumatic event, the medical examiner (must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

024076 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 005545

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 2M 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH / ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
JOHN	GEORGE	McAdam	XX / ☐	2-	6-	89	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR
MALE	WHITE	JAN 8 1937	52 YRS.			2-6-	89	8:02 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
GUYANA	GUYANA		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	HOLY CROSS HOSPITAL	SALESMAN	HUB FURNITURE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES ☒ NO ☐	8103 EASTERN AVE #B205 20910

14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
WILLIAM	McADAM	JOSEPHINE	TOMBY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	577-08-9515	PEGGY McADAM/ WIFE	/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic cardiovascular disease	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above; held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. / D.O. / MEDICAL EXAMINER Acting Deputy Chief DATE SIGNED 2-6-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 10,1989	GATE OF HEAVEN CEMETERY	SILVER SPRING MONTGOMERY MD

24. FUNERAL DIRECTOR NAME AND ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 09'89	Julia Davidson-Randall

07/84 25M BP 7

DHMH - 17 (VR A15 ME (5))

24164 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 055546
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: William	MIDDLE: K.	LAST: McAtee Jr.	2a. DATE KNOWN OF DEATH ESTIMATED: MONTH Jan DAY 31 YEAR 1989	2b. HOUR 11:12 A M			
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 6, 1968	6. AGE (IN YEARS LAST BIRTHDAY): 20 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH, DAY, YEAR: Jan. 31 1989	2d. HOUR 11:12 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Mont. General Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None	12b. KIND OF BUSINESS OR INDUSTRY: None

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md	13b. COUNTY: Mont.	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 13212 Superior Street/20853

14. FATHER'S NAME FIRST / MIDDLE / LAST: William K. McAtee, Sr.		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Sandra Cheek	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 212-92-2067	17. INFORMANT / ADDRESS: William K. McAtee, Sr. same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Muscular Dystrophy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 yrs

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).: None

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Jan 31 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, MD — ADDRESS: 1919 Seminary Rd., Silver Spring, MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 2, 1989	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN: Silver Spring	COUNTY: Maryland / STATE
24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Rockville, Inc. ADDRESS: 300 West Montgomery Ave., Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR: FEB 02 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM, PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 6

DHMH - 17 (VR A15 ME (5))

025359 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05547 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Irene	MIDDLE	LAST: MCCarthy	2a. DATE OF DEATH MONTH DAY YEAR: February 19, 1989	2b. HOUR: 8:19pm	
3. SEX: Female	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: 11 24 99	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County		MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: TAKOMA PARK	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 8401 BARRON STREET 20912	
14. FATHER'S NAME FIRST: ERNEST	MIDDLE	LAST: RAUM	15. MOTHER'S MAIDEN NAME FIRST: MARTHA	MIDDLE	LAST: TOLSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-38-1683	17. INFORMANT: SON JOHN E. McCARTHY	ADDRESS: 5014 RUSSETT ROAD ROCKVILLE, MD 20853	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ASPIRATION PNEUMONIA	2 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)	CEREBROVASCULAR ACCIDENT	5 MONTHS
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11 19 88, to 2/19 19 89, that (I) (we) last saw the deceased alive on 2/19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert Fields MD	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/20/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT FIELDS, MD	22e. ADDRESS: 18111 PR. PHILIP DR, OLNEY, MD 20832		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 22, 1989	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: SUITLAND PRINCE GEORGES MD
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	25a. DATE REC'D. BY REGISTRAR: FEB 22'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024163 FEB 20 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05543
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other unusual circumstances, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: FRANCIS	MIDDLE: MORAN	LAST: McConihe	2a. DATE OF DEATH MONTH DAY YEAR: 1-30-89	2b. HOUR: 2:35 PM	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 8-7-04	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Potomac	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Manor Care Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): President	12b. KIND OF BUSINESS OR INDUSTRY: Banking		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Potomac	YES ☐ NO ☒	11501 Piney Meetinghouse Rd. 20854

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Malcolm	Stuart	McConihe	Eleanor	Berger	Moran

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife) ADDRESS
yes	1922-1942	579 01 2475	Marguerite Hagner McConihe Same as line #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Merkel Cell Carcinoma with Metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Comonths

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Failure, Congestive Heart Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 89, to 1/30/, 19 89, that (I) (we) last saw the deceased alive on 1/29/ 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Richard W. Grey, M.D.	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
David W. SHEA, Jr., M.D.	5401 Western Ave N.W., WDC 20015

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 01, 1989	Rock Creek Cemetery	Washington D.C.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Homes/ Bethesda- Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland	FEB 02 '89	Julia Davidson-Randall

BP 16

DHMH - 16 60M 7/84
(VRA 15, 4)

0205

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005549
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: HENRY MONTGOMERY MCCOY			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 15 1989	2b. HOUR: 6:57 A M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 23 1938	6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DISTRICT OF COLUMBIA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: U.S.C.G.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	PRINCE GEO'S	FT.WASHINGTON	YES ☐ NO ☐	12810 PEACE DRIVE 20744

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
HENRY MCCOY	GENEVA MCFADDEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	1956-1986	577-52-4967	JOYCE MCCOY, 12810 PEACE DRIVE, FT.WASHINGTON, MD 20744

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 14 19 89 to FEBRUARY 15 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
D B Robinson M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN X	1 CORRECTED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
D. B. ROBINSON, LCDR, MC, USNR	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	2-21-89	MD VETRANS CHELTENHAM	CLINTON, MARYLAND

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
COLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019	FEB 23 1989	Julia Davidson-Randall

23646 FEB 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 05550

1. DECEASED NAME (TYPE OR PRINT): FIRST Eugene MIDDLE E. LAST McClung
Eugene E McClung

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 12 YEAR 1989 — 2b. HOUR 1252 PM

3. SEX: male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 10 DAY 11 YEAR 25 — 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 12 YEAR 1989 — 2d. HOUR 520 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter

12b. KIND OF BUSINESS OR INDUSTRY: Self-employed

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Rockville — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 927 Maple Avenue / 20851

14. FATHER'S NAME: FIRST Sidney MIDDLE M. LAST McClung

15. MOTHER'S MAIDEN NAME: FIRST Louie MIDDLE Ella LAST Martin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 236-40-1425

17. INFORMANT ADDRESS: Nina McClung, Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural couses ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Tauber — TITLE (SPECIFY) M.D. MEDICAL EXAMINER — DATE SIGNED 2-12-89

EXAMINER'S NAME (TYPE OR PRINT): John Tauber — ADDRESS: 8218 Wisconsin Ave Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2-15-89 — 23c. NAME OF CEMETERY OR CREMATORY: Wallace Memorial Cemetery — 23d. LOCATION CITY OR TOWN: Clintonville, COUNTY / STATE: West Virginia

24. FUNERAL DIRECTOR NAME AND ADDRESS: Wallace & Wallace, Inc. 213 Main Street, Rainelle, WV 25962

25a. DATE REC'D. BY REGISTRAR: FEB 17 1989 — 25b. REGISTRAR'S SIGNATURE: June Luther

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

Items18a thu22a per M.E. Film G650 4/7/89 CG

22197 FEB-9 89

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05551

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	MICHAEL	D.	MC CRAY	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ — MONTH DAY YEAR	2-2-19 89
2b. HOUR OF DEATH	M				
3. SEX	Male				
4. RACE	Black				
5. DATE OF BIRTH — MONTH DAY YEAR	12 18 1954				
6. AGE (IN YEARS LAST BIRTHDAY)	34 YRS.				
IF UNDER 1 YR. — MONTHS / DAYS					
IF UNDER 24 HRS. — HOURS / MIN.					
2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR	2-2-19 89				
2d. HOUR OF PRONOUNCED DEAD	11:46 P M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Wash. D.C.				
7b. CITIZEN OF WHAT COUNTRY?	U.S.				
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐					
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery County MD.				
10. CITY OR TOWN OF DEATH	Takoma Park				
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Washington Adventist Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Unemployed				
12b. KIND OF BUSINESS OR INDUSTRY	None				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland				
13b. COUNTY	PG				
13c. CITY OR TOWN	Oxon Hill				
13d. INSIDE CITY LIMITS? YES X NO ☐					
13e. STREET ADDRESS	304 Ferndale Place				
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Marshall		Williford		
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Shirley		McCray		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	No				
(IF YES, GIVE WAR OR DATES)					
16b. SOCIAL SECURITY NO.	577-74-3170				
17. INFORMANT — ADDRESS	Shirley McCray 304 Ferndale Place				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute narcotic intoxication
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 2/2/ 89 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Unknown
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) House	21f. LOCATION STREET 1611 Silver Spring Ave. CITY OR TOWN Silver Spring, COUNTY Md. Montgomery STATE MD.

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner X.

ACTUAL SIGNATURE Maria F. Sabla-Acting Deputy Chief TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED 2-3-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	02-08-89	23c. NAME OF CEMETERY OR CREMATORY	Lincoln Memorial Cemetery
23d. LOCATION CITY OR TOWN	Suitland	COUNTY	PG	STATE	Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS	Robert G. Mason 1661 Good Hope Road, SE				
25a. DATE REC'D BY REGISTRAR	2-6-89	25b. REGISTRAR'S SIGNATURE			

07/84 25M BP 335

DHMH - 17 (VR AT5 ME (5))

0 2 3 3 8 3 FEB 22 88 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 0 5 5 5 2 — REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ANNIE; MIDDLE: P.; LAST: McGILL	2a. DATE OF DEATH — MONTH: 1; DAY: 31; YEAR: 89	2b. HOUR: 6:55 AM	
3. SEX: FEMALE	4. RACE: W	5. DATE OF BIRTH — MONTH: 12; DAY: 05; YEAR: 96	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Silver Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SUPERVISOR	12b. KIND OF BUSINESS OR INDUSTRY: Bureau of Engrav
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 20906 12715 Layhill Rd
14. FATHER'S NAME — FIRST: THOMAS; MIDDLE; LAST: MANNION		15. MOTHER'S MAIDEN NAME — FIRST: BARBARA; MIDDLE; LAST: KREBS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579-60-0383	17. INFORMANT: FRIEND — ADDRESS: 12715 LAYHILL ROAD	CARMAN C. RYAN #101 SIL SPR, MD 20906

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): STROKE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I)(this hospital) attended the deceased from 1/3/89, 19__, to 1/31, 19 89, that (I)(we) last saw the deceased alive on 1/30, 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK H. EIG — 22e. ADDRESS: 9801 Georgia Ave Silver Spring MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 2, 1989	23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: WASHINGTON, D.C.
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. — ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 8

DHMH - 16 50M 1/81 (VRA 15, 4)

022096 FEB -9 80 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05553

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) [redacted], Stephen J. McKay.		2a. DATE OF DEATH February 7, 1989	2b. HOUR 12:05 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH APRIL 20. 1954	6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GAS STATION ATTENDANT	12b. KIND OF BUSINESS OR INDUSTRY GASOLINE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	MONT.	GAITHERSBURG	YES ☐ NO ☐	10128 RIDGELINE DRIVE 20879

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
WILLIAM H McKAY	BEVERLY MARROW

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		218 54 6523	BEVERLY M. McKAY	10128 RIDGELINE DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY ARREST	TERM.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	LYMPHOMA BRAIN	3-4 Mo.
DUE TO, OR AS A CONSEQUENCE OF (c)	A.I.D.S.	1 1/2 Yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PULMONARY MOTS - SEPSIS -

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/10, 1988, to 2/4, 1989, that (I) (we) last saw the deceased alive on 2/3, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Donald R. Lewis, M.D. DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 2-4-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS 22e. ADDRESS OLNEY MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	FEB. 7. 1989	St Johns Cemetery	Forest Glen Md

24. FUNERAL DIRECTOR NAME AND ADDRESS: Tilbons Funeral Home, J.A. Tilbon, 25 Carroll Ave N.W. DC

25a. DATE REC'D. BY REGISTRAR FEB 7 1989

25b. REGISTRAR'S SIGNATURE Freda Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

4 BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025381 MAR 16 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055554
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Georgeanna	MIDDLE: Griswold	LAST: McKee	2a. DATE OF DEATH MONTH DAY YEAR: February 18, 1989	2b. HOUR: 1:28 PM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: April 17, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Retirement Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 11201 Huntover Drive/20852
14. FATHER'S NAME FIRST: George	MIDDLE	LAST: Griswold	15. MOTHER'S MAIDEN NAME FIRST: Anna	MIDDLE	LAST: Regan
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 220 44 6109	17. INFORMANT: (Daughter)	ADDRESS: Helen M. Schoolmeester Same as line #13.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral Vascular disease - multiple Cerebral Infarcts.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/18 19 88 to 2/18 19 89 that (I) (last saw the deceased alive on 2/18 19 89) and that in (my) (opinion death occurred on the date and hour and from the causes stated above. (I) (this (did) (did not) view the body after death.

22b. SIGNATURE AND DEGREE: J. Blaine Fitzgerald MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/18/89.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Blaine Fitzgerald, M.D.	22e. ADDRESS: 8218 Wisconsin Avenue Bethesda, Md. 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 22, 1989	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, Maryland

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Homes/ Bethesda- Chevy Chase, Inc. ADDRESS: 7557 Wisconsin Avenue Bethesda, Maryland

25a. ACCEPTED BY REGISTRAR: FEB 21 89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 10

DHMH - 16 60M 7/84
(VRA 15, 4)

023660 FEB 23 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05555
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible] event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	MARK WILLIAM MCKINNEY	2a. DATE OF DEATH MONTH DAY YEAR	FEBRUARY 11 1989	2b. HOUR	10:45 A M
3. SEX	MALE	4. RACE	CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR	OCTOBER 28 1958
6. AGE (IN YEARS LAST BIRTHDAY)	30 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	CALIFORNIA	7b. CITIZEN OF WHAT COUNTRY?	UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH	BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	U.S.A.F.
12b. KIND OF BUSINESS OR INDUSTRY	DEFENSE				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	VIRGINIA	13b. COUNTY	YORK	13c. CITY OR TOWN	HAMPTON
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]		13e. STREET ADDRESS	132C LITTLE BAYAVENUE 23666		
14. FATHER'S NAME FIRST / MIDDLE / LAST	CHARLES MCKINNEY	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	ALICE ANN MCCULLOCH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	YES	(IF YES, GIVE WAR OR DATES)	1978-1989	16b. SOCIAL SECURITY NO.	530-54-4430
17. INFORMANT ADDRESS	SANDRA L.MCKINNEY, 132C LITTLE BAYAVENUE, HAMPTON, VA 23666				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) GLIOBLASTOMA MULTIFORM

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I **certify** that (I) (this hospital) attended the deceased from JANUARY 14 19 89 to FEBRUARY 11 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 11 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	James H Sherry	DEGREE M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED	2/13/89		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	J. SHERRY, LT, MC, USNR	22e. ADDRESS	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Cremation	23b. DATE	2/14/89	23c. NAME OF CEMETERY OR CREMATORY: Chambers Crematory
23d. LOCATION CITY OR TOWN	Riverdale	COUNTY	P.G.	STATE MD
24. FUNERAL DIRECTOR NAME	W.W.Chambers Co. Inc.	ADDRESS	5801 Cleveland Ave. Riverdale Md. 20737	25a. DATE REC'D. BY REGISTRAR: FEB 17 1989
25b. REGISTRAR'S SIGNATURE	Julia Trader Lucas			

BP

DHMH - 1650M 1/81
(VRA 15, 4)

24604 MAR -3 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005556

1. DECEASED NAME (TYPE OR PRINT) First: Ralph	Middle: E	Last: Measell	2a. DATE OF DEATH Month Day Year: 2-25-89	2b. HOUR: 605 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: Jan. 21, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cabinet maker	12b. KIND OF BUSINESS OR INDUSTRY: Gover. Services Adm.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	411 Belton Road 20901

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ira	Daniel	Measell	Rosalie		Coffren

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (daughter)	ADDRESS
Yes	WW11	215-10-7486	Jean Measell	5210 Paducah Road College Pk. Md. 20740

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic prostate carcinoma — Approximate interval between onset and death: 4 years
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from February 10, 19 89, to February 25, 19 89, that (I) (we) last saw the deceased alive on February 24, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael Schindler — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: Feb 25, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MICHAEL SCHINDLER — 22e. ADDRESS: 1106 Spring Street, Silver Spring MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-28-1989	Cedar Hill Cemetery	Suitland / Pr. Georges / Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home	11800 N.H. Ave., Silver Spring, Md.	MAR 1 - 1989	Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual circumstance, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

0 2 5 3 1 4 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 9 0 5 5 5 7

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOSE MIDDLE: TENERIA LAST: MELGAR			2a. DATE OF DEATH MONTH DAY YEAR: 2/18/89	2b. HOUR: M
3. SEX: Male	4. RACE: Hispanic	5. DATE OF BIRTH MONTH DAY YEAR: 6 20 1941	6. AGE (IN YEARS LAST BIRTHDAY): ~~49~~ 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Guatemala	7b. CITIZEN OF WHAT COUNTRY?: Guatemala	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Unemployed	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 1701 E. West Highway #404
14. FATHER'S NAME FIRST MIDDLE LAST: Angel Romeo Teneria		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Graciela Deteneria		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: Unavailable	17. INFORMANT: Graciela Melgar	ADDRESS: 1701 E. West Hwy Silver Spring, Md	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory Arrest	Days
DUE TO, OR AS A CONSEQUENCE OF (b)	Anemia Bl Bleeding	Days
DUE TO, OR AS A CONSEQUENCE OF (c)	Stage Failure	5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/13 19 89, to 2/18 19 89, that (I) (we) last saw the deceased alive on 2/18/89 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/18/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ELBA J. MARTINEZ MD.	22e. ADDRESS: 8808 Hidden Hill Ln. Potomac MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 28, 1989	23c. NAME OF CEMETERY OR CREMATORY: Family Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Guatemala City	
24. FUNERAL DIRECTOR NAME: W.H. Bacon Funeral Hm	ADDRESS: 3447 14th St., W	25a. DATE REC'D. BY REGISTRAR: FEB 21 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

125307 MAR 14 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055583
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 11 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN	MIDDLE: T.	LAST: MERCER, JR	2a. DATE OF DEATH MONTH DAY YEAR: 2/14/1989.	2b. HOUR: 0045 M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: JAN 7 1917	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE HOSPITAL.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Montg.	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 408 McLane Ct/20850
14. FATHER'S NAME FIRST MIDDLE LAST: John T. Mercer, SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Rhoda Onley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 705-10-4462	17. INFORMANT ADDRESS: Molly P. Mercer (wife) same AS #13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): STROKE — 2 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): HYPERTENSION — 10 years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes, Cardiomyopathy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/22 89 to 2/14 89 that (I) (we) last saw the deceased alive on 2/14 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2-14-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): RAYMOND BASS — 22e. ADDRESS: 3941 Ferrara Wheaton, Md 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-17-89	23c. NAME OF CEMETERY OR CREMATORY: Md. Nat'l Mem. Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Laurel, Pr. Geo., MD
24. FUNERAL DIRECTOR NAME / ADDRESS: George R. Snowden Rockville, MD 20850	25a. DATE REC'D. BY REGISTRAR: FEB 15'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 7

DHMH - 1650M 1/81 (VRA 15, 4)

023329 FEB 22 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005559 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: GEORGE	MIDDLE: W. MESLER	LAST: ~~MESSLER~~ MESLER	2a. DATE OF DEATH MONTH DAY YEAR: FEB 4 1989	2b. HOUR: 9:30A M	
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: MAY 1 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MICHIGAN	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALES	12b. KIND OF BUSINESS OR INDUSTRY: ENGINEER		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS: 3615 PEARTREE CT. #11 20906	
14. FATHER'S NAME FIRST: CHARLES	MIDDLE	LAST: MESLER	15. MOTHER'S MAIDEN NAME FIRST: MARY	MIDDLE	LAST: BROWN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 365 09 2790	17. INFORMANT ADDRESS: CHARLES MESLER 4338 SILAS HUTCHINSON DR. CHANTILLY, VA.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from MARCH 11 19 88 to FEBRUARY 4 19 89, that (I) (we) last saw the deceased alive on JANUARY 23 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Allen A. Oboler	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: FEB. 4, 1989	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALLEN A. OBOLER, M.D.	22e. ADDRESS: 8830 CAMERON ST. # 304 SILVER SPRING, MD. 20910		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: FEB5 1989	23c. NAME OF CEMETERY OR CREMATORY: METROPOLITAN CREMATORY	23d. LOCATION CITY OR TOWN: ALEXANDRIA	COUNTY / STATE: VA
24. FUNERAL DIRECTOR NAME AND ADDRESS: FRANCIS J. COLLINS JR. 500 UNIVERSITY BLVD WEST, SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 8

DHMH - 1650M 1/81 (VRA 15, 4)

024299 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05560
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MIRIAM	MIDDLE	LAST: METH	2a. DATE OF DEATH MONTH DAY YEAR: 02/26/89	2b. HOUR: 6:55 P.M.	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 4, 1893	6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Indiana	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner/Operator	12b. KIND OF BUSINESS OR INDUSTRY: Jewelry Store		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 6121 Montrose Road 20852	
14. FATHER'S NAME FIRST: Jacob	MIDDLE	LAST: Brener	15. MOTHER'S MAIDEN NAME FIRST: Rosa	MIDDLE	LAST: Sachs
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 577-52-5332	17. INFORMANT: Leolla Glick	ADDRESS: 4701 Willard Ave. #208 Chevy Chase, Md. 20815	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): BRONCHOPNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c): UNKNOWN ETIOLOGY

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 8/7/84 to 2/26/89, that (I) (we) last saw the deceased alive on 2/26/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M Patel — DEGREE: M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. D. PATEL — 22e. ADDRESS: 6121 MONTROSE RD, ROCKVILLE, MD 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 3/1/89	23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Gdns	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Falls Church, Va.
24. FUNERAL DIRECTOR NAME / ADDRESS: Ives-Pearson Funeral Home, 472 N. Washington St., Falls Church, Va.		25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

0246 89 MAR -3 DME

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

Cleared by Dr. John Rogers DME

REG. NO. 89 055581

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Irene	M.	Miller	Feb. 27 1989	6:40PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Female	White	Jan. 30 1904	85 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Missouri	USA		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	14635 Bauer Drive #218	Gift Shop	Owner

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 20853

12a. STATE	12b. COUNTY	12c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES ☒ NO ☐	14635 Bauer Drive #218

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Walter		Roberts	Mary		Simpson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A	N/A	366-16-4481A	Suzanne J. Conway-daughter-	13505 Sloan St. Rockv. Md.20853

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	coronary arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from ____ 19 88 to 2-27 19 89, that (I) (we) last saw the deceased alive on 2-8 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Donald L Bucy	MD		2-28-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Donald L Bucy MD	809 Viers Mill Rd. Rockville, Md. 20851

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	2-28-1989	Metropolitan Crematory	Alexandria		Virginia

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home	11800 N.H. Ave., Silver Spring, Md.	MAR 1 - 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024048 FEB 23

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05562
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR			
Cynthia	E.	Mitchell	2-15-89			M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	Black	4	24	60	28 YRS.				
2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR	2d. HOUR						
2-15-		19 89	1:00 P M						

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, D.C.	United States		Montgomery County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	7700 Old George Town Road	Collection Clerk	Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	PG	Landover	YES XX NO ☐	7756 Normandy Roa

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Shirley		Mitchell	Vera		Mathis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	219-72-5423	Vera Mitchell	7756 Normandy Rd. Landover, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Gunshot wound to head	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	12:50PM 2-15-89 19	Subject shot
21d. INJURY OCCURRED	**21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)**	**21f. LOCATION** STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK XX NOT WHILE AT WORK ☐	building	7700 Old George Town Road, Bethesda, Montgomery County, Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy XX Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide XX, Undetermined manner ☐.

ACTUAL SIGNATURE _____ TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER — DATE SIGNED 2-16-89

VC EXAMINER'S NAME (TYPE OR PRINT) James Kaplan, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	21 Feb 89	Harmony Memorial Park	Landover	PG	Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
JB Jenkind FH/7474 Landover Rd. Landover, MD	FEB 23 1989	Julia Davidson-Randall

07/84 25M BP_____

DHMH - 17 (VR A15 ME (5))

025340 MAR 16 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055563 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN MIDDLE: EDWARD LAST: MOORE, SR.			2a. DATE OF DEATH MONTH DAY YEAR: 2 16 89	2b. HOUR: 4 AM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 2 15 09	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MOntgomery MD.		
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Salesman	12b. KIND OF BUSINESS OR INDUSTRY: Dictaphone Corp.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. Georges	Hyatts.	YES ☒ NO ☐	1711 Dayton Road 20783

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST JOHN MIDDLE E. LAST MOORE	FIRST ANASTACIA MIDDLE LAST BYRNE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A	N/A	223-01-8520	John E. Moore, Jr.-son	4500 Prestwood Dr. Olney, Md. 20832

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b): SEPTIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF (c): SPONTANEOUS PERITONITIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): RENAL FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 2/6/89 to 2/16/89, that (I) (we) last saw the deceased alive on 2/15/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
	MD	☒ / ☐ / ☐	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
K. SUBHAKAR, MD	7610 CARROLL AVE #230 TAKOMA PARK, MD 20912

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-18-1989	GAte of Heaven Cemetery	Silver Spring Montgomery Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home	11800 N.H. Ave. Silver Spring Md.	FEB 21 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

3

023162 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05564 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Ozell	Middle: J	Last: Moore	2a. DATE OF DEATH Month Day Year: 1-30-89	2b. HOUR: 11:30 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month Day Year: May 10 1920	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Virginia	13b. COUNTY	13c. CITY OR TOWN: Radford	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 15 Grandview Drive	
14. FATHER'S NAME First: W.	Middle: W.	Last: Jones	15. MOTHER'S MAIDEN NAME First: Vivian	Middle: Laura	Last: Thompson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 227-09-1199	17. INFORMANT: Charles Jones	ADDRESS: Roanoke, VA.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): MASSIVE CEREBRAL HEMORRHAGE — ~10 hrs

DUE TO, OR AS A CONSEQUENCE OF (c): ATHEROSCLEROTIC ARTERIOSCLEROSIS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/30 19 89 to 1/30 19 89, that (I) (we) last saw the deceased alive on 1/30 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): (Gerald) Topak M.D. — 22e. ADDRESS: 5530 Wisconsin Ave Ch. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/2/89	23c. NAME OF CEMETERY OR CREMATORY: Westview	23d. LOCATION CITY OR TOWN: Radford	COUNTY / STATE: Virginia
24. FUNERAL DIRECTOR NAME / ADDRESS: DeVilbiss Funeral Home - Radford, VA. 24141	25a. DATE REC'D. BY REGISTRAR: FEB 08 1989	25b. REGISTRAR'S SIGNATURE: [signature]		

BP

DHMH-16 50M 1/81 (VRA 15, 4)

024095 FEB 28 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05565
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Melvin MIDDLE H. LAST MORAN
2a. DATE OF DEATH: MONTH 2 DAY 07 YEAR 89
2b. HOUR: 9:05 A M
3. SEX: MALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MONTH 8 DAY 25 YEAR 02
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TRUCK DRIVER
12b. KIND OF BUSINESS OR INDUSTRY: O'BOYLE TANK LINE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: SILVER SPRING
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET ADDRESS: 723 SILVER SPRING AVE 20901

14. FATHER'S NAME: FIRST HARVEY MIDDLE W. LAST MORAN
15. MOTHER'S MAIDEN NAME: FIRST ZADIE MIDDLE MAE LAST SCHNEIDER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 578-09-2676
17. INFORMANT ADDRESS: MARION J. MORAN/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Pulmonary Emboli — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO, OR AS A CONSEQUENCE OF (b): Thrombophlebitis — 2 mos
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral Atrophy, Staphylococcus Septicemia

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 19 88 to 2/7 19 89, that (I) (we) last saw the deceased alive on 2/7 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/7/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): 4115 Colie Dr. T. Benack MD
22e. ADDRESS: 4115 Colie JR. Wheaton

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: FEB 10, 1989
23c. NAME OF CEMETERY OR CREMATORY: GEORGE WASHINGTON CEM
23d. LOCATION: CITY OR TOWN ADELPHI COUNTY PRINCE GEORGES STATE MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901
25a. DATE REC'D. BY REGISTRAR: FEB 09'89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 50M 1/81
(VRA 15, 4)

0 2 3 1 3 6 FEB 17 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05566 — REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Garth	Halley	Mortenson	February 11, 1989	10:53a M

3. SEX	4. RACE	5. DATE OF BIRTH Month Day Year	6. AGE (IN YEARS LAST BIRTHDAY)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	Caucasian	Sept. 25, 1904	84 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Missouri	USA	X MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General Hospital	Credit Mgr.-Iowa Power & Light	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Iowa	Pottawattamie	Council Bluffs	YES ☐ NO X	1110 E. Washington Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James		Mortenson	Ella		Quinn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	480 09 3056	Margaret Mortenson	same address #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Pulmonary Edema

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Aspiration

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/19/89	Urinary Retention	YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~XXXXXX~~ attended the deceased from _____ 19____, to _____ 19____, that (I) (~~we~~) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Robert L Gold MD	MD	ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert L. Gold, M.D. Dr. Gold	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 16, 1989	Walnut Hill Cemetery	Council Bluffs, Io

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ives-Pearson Funeral Homes	Arlington, Va. 22201	FEB 15 1989	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 10 50M 1/81 (VRA 15, 4)

025383 MAR 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 05567 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Bhagwandas	Middle: R.	Last: Motwane	2a. DATE OF DEATH Month Day Year: February 18, 1989	2b. HOUR: 9:00 AM	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH Month Day Year: December 1, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): India	7b. CITIZEN OF WHAT COUNTRY?: India	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4 Brassie Court	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner	12b. KIND OF BUSINESS OR INDUSTRY: Electronics		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 4 Brassie Court/ 20879	
14. FATHER'S NAME First: Ramkrishen	Middle:	Last: Motwane	15. MOTHER'S MAIDEN NAME First: Dyali	Middle:	Last: Kewalramani
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 047-64-6381	17. INFORMANT: Mrs. Surita Tewani, Daughter,	ADDRESS: 37 Jefferson Crt. Freehold, NJ.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Atherosclerotic Heart Disease	10 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) ~~XXXXXXX~~ attended the deceased from September, 19 85, to February, 19 89, that (I) ~~XX~~ last saw the deceased alive on Nov. 15, 19 88, and that in (my) ~~XX~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~XXXX~~ (did not) view the body after death.

22b. SIGNATURE: Michael L. Weinstein	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: Feb.18,1989	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael L. Weinstein, M.D.	22e. ADDRESS: 916 19th Street, N.W. #108 Washington, D.C. 20006		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: February 19, 1989	23c. NAME OF CEMETERY OR CREMATORY: Montgomery Crematorium	23d. LOCATION CITY OR TOWN: Bethesda	COUNTY / STATE: Maryland
24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. ADDRESS: 7557 Wisconsin Avenue, Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

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FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055683
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in obtaining transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if the death occurred between midnight and 18 hours any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Blanche	MIDDLE: A.	LAST: Murray	2a. DATE OF DEATH MONTH DAY YEAR: 2-20-89	2b. HOUR: 2215 P M	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: May 5, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wash. Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic	12b. KIND OF BUSINESS OR INDUSTRY: Cleaning		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: P.G.	13c. CITY OR TOWN: N. Brentwood	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 4509 40th St. 20722	
14. FATHER'S NAME FIRST: Edward	MIDDLE:	LAST: Gross	15. MOTHER'S MAIDEN NAME FIRST: Elizabeth	MIDDLE:	LAST: Coates
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-30-9434	17. INFORMANT: Samuel Gross-Same as # 13 above	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory and Cardiac Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Severe Congestive Heart Failure	
DUE TO, OR AS A CONSEQUENCE OF (c)	Acute renal failure	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/6/89, 19__, to 2/20/89, 19__, that (I) (we) last saw the deceased alive on 2/20, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Smith S. HO DEGREE: ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): SMITH HO., M.D. 7610 Carroll Ave — 22e. ADDRESS: 7610 Carroll Ave. Takoma Pk Md 20912

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: 2/27/89	23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEM. PK.	23d. LOCATION CITY OR TOWN: LANDOVER	COUNTY: P.G. STATE: MD.
24. FUNERAL DIRECTOR NAME: N.S. WASHINGTON & SONS	ADDRESS: 4925 BUCHANAN AVE N.E.	25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP____

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(VRA 15, 4)

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FORM 1 – STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005569
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Marjorie Ann Murray	2a. DATE OF DEATH MONTH DAY YEAR	1-26-1989
		2b. HOUR	20:30 M
3. SEX	Female	4. RACE	Cacasian
5. DATE OF BIRTH MONTH DAY YEAR	4 07 1928	6. AGE (IN YEARS LAST BIRTHDAY)	60 YRS.
IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Queens, New York	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery MD.
10. CITY OR TOWN OF DEATH	Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Washington Adventist Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Account Clerk	12b. KIND OF BUSINESS OR INDUSTRY	Univ. Of MD

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Burtonsville	YES ☒ NO ☐	14713 Valiant Terrace 20866

14. FATHER'S NAME FIRST / MIDDLE / LAST	Herman G. Schoen	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Beatrice Murphy
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	no / no	16b. SOCIAL SECURITY NO.	080-22-9770
17. INFORMANT / ADDRESS	John Murray same as 13e		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Staphylococcal Septicemia	2 wks
DUE TO, OR AS A CONSEQUENCE OF (b)	Pancytopenia	6 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Metastatic Breast Cancer	5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 15 Nov, 19 87, to 26 Jan, 19 89, that (I) (we) last saw the deceased alive on 26 Jan, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Thomas A. Bernacki	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	1/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Thomas A. Bernacki	7525 Greenway Ctr. Dr. Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	1-27-89	Balt. Wash. Crematory	Laurel P.G. Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, MD 20707	FEB 02 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP b

DHMH-16 50M 1/81 (VRA 15, 4)

022799 FEB 15 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05570
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT - If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
JAMES	R.	MURPHY	FEB	9	89 / 655 P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	Feb.	20	1892	96 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Milford Mass.	U.S.A.		MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (KIND OF WORK DONE MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
TAKOMA PARK	HERITAGE HEALTH CARE CENTER	U.S. Post Office	Traffic Dir.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Washington	D. C.	Washington.	YES ☐ NO ☐	745 Varnum St. N. W. D. C.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
		Murphy.	Elizabeth.		S. S. Md.

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes.	W. W. I.	579-60-8391	James F. Murphy.	9727 Mt. Pisgah Rd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/8/89, 19____, to 2/9/89, 19____, that (I) (saw) last saw the deceased alive on 2/8/89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Norton Elson MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
NORTON ELSON	6525 Belcrest Rd #605 Hyattsville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb. 14 89	Arlington National Cemetery	Arlington		Va.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tokins Funeral Home & Cremation	254 Carroll St NW DC	FEB 13 1989	

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(VRA 15, 4)

023390 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055 71 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert	MIDDLE: A.	LAST: Neff	2a. DATE OF DEATH MONTH DAY YEAR: 01/27/89	2b. HOUR: 6:58 P.M.	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: March 8, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman	12b. KIND OF BUSINESS OR INDUSTRY: Sales		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 263 Congressional Lane Apt. 406	20852
14. FATHER'S NAME FIRST: Ralph	MIDDLE: A.	LAST: Neff	15. MOTHER'S MAIDEN NAME FIRST: Ethel	MIDDLE: May	LAST: Comming
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 273-16-1914	17. INFORMANT: Alice H. Neff; 263 Congressional La. #406	ADDRESS: Rockville 20852	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Irreversible Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: One month
DUE TO, OR AS A CONSEQUENCE OF (b): Severe Chronic Obstructive Pulmonary Disease — many years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive heart failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from December 27 19 88 to January 27 19 89, that (I) (we) last saw the deceased alive on January 27 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James E. Wilson	DEGREE: M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1/28/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): James E. Wilson, Jr. M.D.	22e. ADDRESS: 11125 Rockville Pike, Ste. 103, Rockville, Md. 20852		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: Jan. 30, 1989	23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory	23d. LOCATION CITY OR TOWN: Alexandria,	COUNTY / STATE: VA
24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home;	ADDRESS: 1331 Rockville Pike Rockville 20852	25a. DATE REC'D. BY REGISTRAR: JAN 31 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 101

DHMH - 1650M 1/81 (VRA 15, 4)

024156 FEB 29 89 FOR STATE REGISTRAR CC

Items18a thru 22a per M.E. Film650 4/7/89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05572
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BUREAU OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

(VR A15 ME (5))

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Robert	MIDDLE: Carl	LAST: Nelson	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH DAY YEAR: 2-3-89	2b. HOUR: M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: APR 4 1956	6. AGE (IN YEARS LAST BIRTHDAY): 32 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-3- 89	2d. HOUR: 5:15A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.			
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 8915 Pennsylvania Ave.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ELECTRICIAN	12b. KIND OF BUSINESS OR INDUSTRY: UNION 26				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 8915 PENNSYLVANIA AVE 20910			
14. FATHER'S NAME FIRST: RUDOLPH	MIDDLE: C.	LAST: NELSON	15. MOTHER'S MAIDEN NAME FIRST: JOANNE	MIDDLE:	LAST: HONGELL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-64-9466	17. INFORMANT: MOTHER JOANNE NELSON	ADDRESS: 1634 JUNO TRAIL ASTOR, FLORIDA 32002			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hanging
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: P.M 2/3/89 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject hanged self
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 8915 Pennsylvania Ave. Silver Spring Montgomery Md.

22a. I certify that I took charge of the remains described above and held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE: Charles P. Kokes TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED: 2-3-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: FEB 7, 1989	23c. NAME OF CEMETERY OR CREMATORY: METROPOLITAN CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: ALEXANDRIA / VA	
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

025274 MAR 1989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 05573

1. DECEASED NAME (TYPE OR PRINT): FIRST Thu MIDDLE VAN LAST Nguyen

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH Feb DAY 14 YEAR 89

2b. HOUR 5:35 P.M.

3. SEX M

4. RACE W

5. DATE OF BIRTH: MONTH DEC DAY 8 YEAR 1926

6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 14 YEAR 89

2d. HOUR 5:36 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIETNAM

7b. CITIZEN OF WHAT COUNTRY? VIETNAM

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.

10. CITY OR TOWN OF DEATH Sil. Spg.

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICEMAN

12b. KIND OF BUSINESS OR INDUSTRY VIETNAM

USUAL RESIDENCE (IF INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE md

13b. COUNTY Mont.

13c. CITY OR TOWN Sil. Spg.

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS 4007 Hillsboro Dr. 20902

14. FATHER'S NAME: FIRST TRON MIDDLE GUAN LAST PHAM

15. MOTHER'S MAIDEN NAME: FIRST THIEN MIDDLE THI LAST NGUYEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 233-19-3796

17. INFORMANT SON-IN-LAW KI GIA LY ADDRESS 1106 CHICKASAW DRIVE SILVER SPRING, MD 20903

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Brs.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardia Dis

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

None

19a. DATE OF OPERATION None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Dep. MEDICAL EXAMINER DATE SIGNED Feb 15 1989

EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.D. ADDRESS 1919 SEMINARY ROAD SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

23b. DATE FEB 17, 1989

23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY

23d. LOCATION CITY OR TOWN SUITLAND COUNTY PRINCE GEORGES STATE MD

24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25a. DATE REC'D. BY REGISTRAR FEB 17'89

25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP 1

DHMH - 17
(VR A15 ME (5))
20M 4/82

025364 MAR 16 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05574
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certification has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CECIL	MIDDLE: M.	LAST: NICHOLS	
2a. DATE OF DEATH MONTH DAY YEAR: 2-19-89	2b. HOUR: 330 PM		
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: NOV. 16, 1908	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TENNESSEE	7b. CITIZEN OF WHAT COUNTRY?: USA.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RET. EDITOR	12b. KIND OF BUSINESS OR INDUSTRY: NAT'L. ACADEMY OF SCIENCES
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 8513 BRADFORD RD. 20901			
14. FATHER'S NAME FIRST: WILLIAM	MIDDLE	LAST: NICHOLS	15. MOTHER'S MAIDEN NAME FIRST: ETHEL MIDDLE: W. LAST: SKILES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 217-44-0428A	17. INFORMANT ADDRESS: ERNA NICHOLS (SAME AS #13)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 HRS.
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION: 2/17/89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gangrene (L) Leg	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/28 19 89 to 2/19 19 89, that (I) (we) last saw the deceased alive on 2/19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Louis Kozloff — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LOUIS KOZLOFF, M.D.

22e. ADDRESS: 8218 WISCONSIN AVE. BETHESDA, MD. 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 2-21-1989	23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: RIVERDALE, PGC., MD.	
24. FUNERAL DIRECTOR NAME / ADDRESS: W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910	25a. DATE REC'D. BY REGISTRAR: FEB 22 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 5

DHMH - 1650M 1/81
(VRA 15, 4)

024149 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005575

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon paper and pages 3 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal. IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Nellie MIDDLE: B. LAST: Nicholson				2a. DATE OF DEATH MONTH DAY YEAR: 1-27-89	2b. HOUR: 2PM
3. SEX: F	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: March 8, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Management Home Economics	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Phoenix	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS / ZIP CODE: 3913 Longmoor Circle 21131	
14. FATHER'S NAME FIRST: Charles MIDDLE LAST: Buckey			15. MOTHER'S MAIDEN NAME FIRST: Florence MIDDLE LAST: Tate		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-40-4518	17. INFORMANT ADDRESS: Robert Nicholson, 3913 Longmoor Cir., Phoenix, MD 21131		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Dementia 2nd to organic brain synd.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Alzheimer's disease
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Possible small intestinal ob.st.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from March 21, 19 88, to Jan 27, 19 89 that (I) (we) last saw the deceased alive on Jan 12, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James R. Moore Jr. DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 1-27-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): James R. Moore Jr.
22e. ADDRESS: 207 Brookes Ave Gaithersburg

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 1/30/89	23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Alexandria, Alexandria, VA	
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wiscomsin Ave. NW Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 10

DHMH - 16 60M 7/84
(VRA 15, 4)

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024097 FEB 28 19

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055576
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Charles	MIDDLE: E	LAST: Nicholson, Sr.	2a. DATE OF DEATH MONTH DAY YEAR: 2-7-89	2b. HOUR: 1358 M		
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 04 26 97	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.			
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Supervisor	12b. KIND OF BUSINESS OR INDUSTRY: Rockville Sanitation Dept			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES ☒ NO ☐	521 Woodston Road/20850

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James		Nicholson	Bessie		Price

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		217-05-9523	Shirley A. Kelley, same as #13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio/respiratory arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	congestive heart failure	
DUE TO, OR AS A CONSEQUENCE OF (c)	C O P D.	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): pneumonia.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/7 19 89 to Feb 7 19 89, that (I) (we) last saw the deceased alive on 2/7 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
	MD	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARIO Q BELLEDONNE	14816 PHYSICIANS LN 251 ROCKV.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb.10,1989	Mt. Carmel Cemetery	Sunshine, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, MD 20850	FEB 09'89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 7

DHMH - 16 50M 1/81 (VRA 15, 4)

0239 Dr. Tuska
Spoke to NF who will file FEB 23 1989
Need Nurs.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR 3169

89 05577
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
MELVIN		NOLAN	02	18	89	0745 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	12	19	27	61 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
	U.S.A.		MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
ROCKVILLE	SHADY GROVE ADVENTIST HOSPITAL		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Rhabdomyolysis	30 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Exposure - thermal	?
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-16 19 89, to 2-18 19 89, that (I) (we) last saw the deceased alive on 2-17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Alison Norris	MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-19-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ALISON NORRIS	14915 Broschart Rd Rockville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Removal	2-22-89				

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
State Anatomy Board	Balto., MD.	FEB 24 1989	Jeanne Davidson Rendeo

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81
(VRA 15, 4)

023373 FEB 2 2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 055738 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WITHOUT THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH / ESTIMATED (MONTH DAY YEAR)	2b. HOUR	3. SEX	4. RACE
Andrew	Leahy	Norris	Jan 26 1989	1500 M	Male	Caucasian

5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD (MONTH DAY YEAR)	2d. HOUR
Feb. 5, 1917	71 YRS.					Jan 26, 1989	1505 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	United States	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Mont. General Hosp	Stock Clerk/	Montgomery County Transportation

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Mont	Rockville	YES ☐ NO XX	16323 Emory Lane / 20853

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	Andrew	Norris	Hannah	Jane	Leahy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	578-09-2163	Alice I. Norris, Wife,	Same as item #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Dis.	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
None		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dept MEDICAL EXAMINER DATE SIGNED: Jan 26/1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS: 1919 Seminary Road Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	January 30, 1989	Gate of Heaven Cemetery	Silver Spring		Maryland

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland	JAN 31 '89	Julia Davidson-Randall

07/84 25M

BP 1571

DHMH - 17 (VR A15 ME (5))

024080 FEB 28 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005579

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Edward	C	O'Connell	Feb. 6, 1989	8 p M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	Mar. 14, 1929	59 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
CO	U.S.A.		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Kensington	9604 Culver Street	Attorney	Pvt. Practice

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Mont.	Kensington	YES ☒ NO ☐	9604 Culver St. 20895

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph		O'Connell	Winifred		Collins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Korea	577-32-9998	Brian O'Connell	11511 Soward Dr. 20902 Silver Spring, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory Arrest	4 min
DUE TO, OR AS A CONSEQUENCE OF (b)	Cardiac Arrhythmia	1 min
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Artery Disease	6 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(b).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 1 19 87, to Feb. 6th 19 89, that (I) (we) last saw the deceased alive on Jan 30 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Phillip W. Poth, M.D.	Suite 32 831 University Blvd. East, Silver Spring, Md. 20903

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-9-89	Gate of Heaven Cem.	Silver Spring, MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016	FEB 08 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 30+1

DHMH - 16 50M 1/81 (VRA 15, 4)

025373 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05580 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Veronica MIDDLE:	LAST: OFFENBACHER Offenbacher	2a. DATE OF DEATH MONTH DAY YEAR: 2/17/89	2b. HOUR: 1035 M		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 12 29 05	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Hungary	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: own home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Sil. Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 321 Univ. Blvd.,	Apt. 232 20901
14. FATHER'S NAME FIRST: Joseph MIDDLE: LAST: Offenbacher		15. MOTHER'S MAIDEN NAME FIRST: Katharine MIDDLE: LAST: Distl			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	16b. IF YES, GIVE WAR OR DATES: N/A	16b. SOCIAL SECURITY NO.: 141-05-7382	17. INFORMANT: Kathryn Scrocco- Niece	ADDRESS: 13504 Creekside Dr. Sil. Spr. Md. 20904	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Stroke - CVA
DUE TO, OR AS A CONSEQUENCE OF (b): Sepsis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): peripheral vascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb. 1989 to Feb. 17, 1989, that (I) (we) last saw the deceased alive on Feb. 17, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Hector K Collinson	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/18/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Hector K. Collinson	22e. ADDRESS: 1111 Spring St. S.S. Md. 20910	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if the circumstances shows any injury, or other traumatic event, the medical examiner must be notified at once.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-21-1989	23c. NAME OF CEMETERY OR CREMATORY: GAte of Heaven	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR: Hines/Rinaldi Funeral Home	ADDRESS: 1800 N.H. Ave. Silver Spring, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

024140 FEB 29 89

FOR USE BY REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005581

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "DEFERRED" OR "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Walter	MIDDLE: J.	LAST: O'Hagan	2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ]	MONTH: 1	DAY: 25	YEAR: 89	2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: March 19, 07	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YR. MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:	2c. DATE PRONOUNCED DEAD: 1-25-89				2d. HOUR: 7:47P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [XX] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.									
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Correspondent	12b. KIND OF BUSINESS OR INDUSTRY: Newspaper									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: New York	13b. COUNTY: Cayuda	13c. CITY OR TOWN: Auburn	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 7 Sherman Street 99999								
14. FATHER'S NAME FIRST: Peter	MIDDLE:	LAST: O'Hagan	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE:	LAST: Rice							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	IF YES, GIVE WAR OR DATES:	16b. SOCIAL SECURITY NO.: 069-03-8826	17. INFORMANT: Thomas O'Hagan (Son)	ADDRESS: 11452 Oak Leaf Dr. Silver Spring, Md								

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. 7:15PM MONTH 1 DAY 25 YEAR 1989	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Pedestrian struck by auto	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road	21f. LOCATION STREET: Oak Leaf Drive & Rt. 29, CITY OR TOWN: Silver Spring, COUNTY: Montgomery Co., MD	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Marjorie Mochtell for/ M.D. TITLE (SPECIFY): Chief MEDICAL EXAMINER DATE SIGNED: 1-26-89

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	1/30/89	St. Joseph's Cemetery	Fleming	Cayuda	N.Y.

24. FUNERAL DIRECTOR NAME: Hines/Rinaldi F.H. ADDRESS: 11800 New Hampshire Ave Silver Spring, MD.

25a. DATE REC'D. BY REGISTRAR: FEB 01 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

07/84 BP

999999

024315 FEB 29 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05582
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Pansy MIDDLE R LAST Olive

2a. DATE OF DEATH: MONTH DAY YEAR 2-17-89 | 2b. HOUR 0800 A M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH 10 DAY 15 YEAR 1918

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk Interior Dept.U.S. Government

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland | 13b. COUNTY: Prince George | 13c. CITY OR TOWN: Bowie | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: 135011 Woodedge Drive 20715

14. FATHER'S NAME: FIRST Joseph MIDDLE J. LAST Olive

15. MOTHER'S MAIDEN NAME: FIRST Vivian MIDDLE LAST Harris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 244-26-7659

17. INFORMANT ADDRESS: Linda O. Sickles Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Broncho alveolar lung CA — 3 months

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/27 19 89 to 2/17 19 89, that (I) (we) last saw the deceased alive on 2/16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: N Placentra DO | DEGREE: D.O. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Nicholas Placentra D.O.

22e. ADDRESS: 11018 Lockwood Dr, Silver Spring MD 20901

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-21-89

23c. NAME OF CEMETERY OR CREMATORY: Mont Lawn Memorial

23d. LOCATION: CITY OR TOWN Raleigh COUNTY Wake STATE North Carolina

24. FUNERAL DIRECTOR: NAME Beall-Evans Funeral Home, P.A. ADDRESS 16000 Annapolis Rd. Bowie, Maryland 20715 Park

25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989

25b. REGISTRAR'S SIGNATURE: Julia Taylor-Bender

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

025342 MAR 16 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05583
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the local registration permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Arne; MIDDLE: ; LAST: Olson			2a. DATE OF DEATH (MONTH DAY YEAR): 2/23/89	2b. HOUR: 11:00 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH (MONTH DAY YEAR): 8 29 05	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Minn	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9103 Providence Ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION: GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 9103 Providence Ave 20901
14. FATHER'S NAME FIRST: GIDEON; MIDDLE: ; LAST: OINONEN			15. MOTHER'S MAIDEN NAME FIRST: NAMIE; MIDDLE: ; LAST: Kalajainen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES):		16b. SOCIAL SECURITY NO.: 371-05-4501	17. INFORMANT: EDWIN E. OLSON SON ADDRESS: 5650 VANTAGE POINT RD COLUMBIA, MD 21044	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY ARREST	IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF (b)	METASTATIC GASTRIC CANCER	20 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 1 19 89 to Feb 23 19 89 that (I) (we) last saw the deceased alive on 2/17 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark E. Ellis	DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/23/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK E. ELLIS, M.D.	22e. ADDRESS: 7525 Greenway Center Drive Greenbelt, MD 20770	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 25, 1989	23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: ROCKVILLE MONTGOMERY MARYLAND
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D BY REGISTRAR: FEB 24 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 5

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 055584

023158 FEB 1 '89

1. DECEASED NAME (TYPE OR PRINT) FIRST Ethel MIDDLE A. LAST Osborne

2a. DATE OF DEATH MONTH DAY YEAR 2/6/89

2b. HOUR 5:30 A.M.

3. SEX Female

4. RACE Caucasian

5. DATE OF BIRTH MONTH DAY YEAR Jan. 2, 1899

6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unavailable

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.

10. CITY OR TOWN OF DEATH Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Heath Care Center - Asbury

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker

12b. KIND OF BUSINESS OR INDUSTRY Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY Montgomery

13c. CITY OR TOWN Gaithersburg

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE 301 Russell Ave 20877

14. FATHER'S NAME FIRST Charles MIDDLE LAST Woodworth

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Farley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 578-48-8346

17. INFORMANT (daughter-in-law) ADDRESS Vera Osborne 12377 Wellington Park DR Houston, TX 77072

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-1, 19 88, to 2-6, 19 89, that (I) (~~was~~ last saw the deceased alive on 2-1, 19 89, and that in (my) (~~mine~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (~~did~~) (~~did not~~) view the body after death.

22b. SIGNATURE John Tauber DEGREE MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED 2-6-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber

22e. ADDRESS 8218 Wisconsin Ave Bethesda MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 13 Feb. 89

23c. NAME OF CEMETERY OR CREMATORY Evergreen Burial Park

23d. LOCATION CITY OR TOWN Roanoke, VA COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS Capitol Funeral Service, Falls Church, VA

25a. DATE REC'D BY REGISTRAR FEB 13 1989

25b. REGISTRAR'S SIGNATURE Barbara Davidson-Hendricks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Items 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

022102 FEB-9 03

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055585
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Julia Middle: Chor-Kwan Last: Pak				2a. DATE OF DEATH Month: 2 Day: 4 Year: 89	2b. HOUR: 12 PM
3. SEX: FEMALE	4. RACE: Chinese	5. DATE OF BIRTH Month: 11 Day: 24 Year: 44		6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): China	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital of Silver Spring			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ass't Staff Mgr.	12b. KIND OF BUSINESS OR INDUSTRY: Telecommunications
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 2229 Falling Creek Road / 20904	
14. FATHER'S NAME First: Paul Middle: Pao-Ling Last: Li				15. MOTHER'S MAIDEN NAME First: Man-Chiao Middle: Last: Sung	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 452-98-3314		17. INFORMANT ADDRESS: Yue-Leung Pak, Same as 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma, ∞ — Approximate interval between onset and death: 4 months
DUE TO, OR AS A CONSEQUENCE OF (b): Renal pelvic transitional cell Ca — 13 months
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan 7th 19 89 to Feb 4th 19 89, that (I) (we) last saw the deceased alive on Feb 4th 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bernadette C.F. Soong — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: Feb. 4, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Bernadette C.F. Soong

22e. ADDRESS: 1106 Spring St #2 Silver Spring md 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2-5-89	23c. NAME OF CEMETERY OR CREMATORY: Suburban Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910		25a. DATE REC'D. BY REGISTRAR: FEB 7 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

025371 MAR 6 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055586
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit; then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 pertains to injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: STANLEY	MIDDLE: W	LAST: PARROTT	2a. DATE OF DEATH MONTH: 02 DAY: 16 YEAR: 89	2b. HOUR: 5:26 PM
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: MAR. DAY: 5, YEAR: 1930	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Computer Tech	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Montg.	13c. CITY OR TOWN: Sandy Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 15 Branchwood Ct. 20860
14. FATHER'S NAME FIRST: Julius MIDDLE: Parrott LAST:		15. MOTHER'S MAIDEN NAME FIRST: Beulah MIDDLE: Hopkins LAST:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-24-7089	17. INFORMANT: Saunders Parrott (SON)	ADDRESS: 3401 Hewitt Ave Silver Spring MD	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b): MYOCARDIAL INFACTION & VENTRICULAR
DUE TO, OR AS A CONSEQUENCE OF (c): ANGURYSM
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PULMONARY HYPERTENSION.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 1989 to Feb 16 19 89, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Kamalnv Deshpande	DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-18-1989	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): KAMALNV DESHPANDE	22e. ADDRESS: 6001 Executive Lane Rockville MD 20852		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-21-89	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.	23d. LOCATION CITY OR TOWN: Silver Spring	COUNTY / STATE: Montg. MD
24. FUNERAL DIRECTOR NAME: George R. Snowden ADDRESS: Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

23406 FEB 22 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05587 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Donald	MIDDLE	LAST: Parsley	2a. DATE OF DEATH MONTH DAY YEAR: February 15, 1989	2b. HOUR: 4:15 AM	
3. SEX: Male	4. RACE: C	5. DATE OF BIRTH MONTH DAY YEAR: 12 14 35	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY		MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Howard	13c. CITY OR TOWN: DAYTON	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 4244 TEN OAKS ROAD	DAYTON 21036
14. FATHER'S NAME FIRST: HOMER	MIDDLE: C	LAST: PARSLEY	15. MOTHER'S MAIDEN NAME FIRST: JOSEPHINE	MIDDLE	LAST: RAY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-36-1322	17. INFORMANT: MAE PARSLEY	ADDRESS: DAYTON, MD 21036	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RENAL FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
DUE TO, OR AS A CONSEQUENCE OF
(b): METASTATIC MALIGNANT MELANOMA
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from JULY, 19 88, to 2/15, 19 89, that (I) (we) last saw the deceased alive on 2/14, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did / did not view the body after death.

22b. SIGNATURE: Evelyn Jackson — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Evelyn Jackson, M.D. — 22e. ADDRESS: 5540 TEN OAKS RD CLARKSVILLE MD 21029

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-17-89	23c. NAME OF CEMETERY OR CREMATORY: MT. VIEW CEMETERY	23d. LOCATION CITY OR TOWN: MARRIOTTSVILLE	COUNTY: HOWARD	STATE: MD
24. FUNERAL DIRECTOR NAME: HAIGHT FUNERAL HOME	ADDRESS: BOX 195, SYKESVILLE MD. 21784	25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

Item # 16b Film G649 3/21/89 CG

023943 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005583

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Paul	L	Pattyson	February 16 1989	855	P/M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
M Male	Caucasian	3 05 20	68 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	U.S.A.		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital	Optician	Private		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS	
Maryland	P.Geo.	Silver Spring		8819 Lainer Dr. 20910	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Wilbur		Pattyson	Mattie		Lesser
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
Yes	WW11	081169264	Jeffrey P. Pattyson	7429 Convair Dr. Alex., Va. 22306	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) HEPATORENAL FAILURE, RESPIRATORY FAILURE — Approximate interval between onset and death: 3 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CARRHOSIS of the LIVER — XX yrs

DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOLISM — XX yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): GASTRO INTESTINAL HEMORRHAGE,

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
—	—		

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/13/89, 19__, to 2/16, 1989, that (I) (we) last saw the deceased alive on 2/16, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED 2/17/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASQUEZ, CARLOS	22e. ADDRESS 10510 CONNECTICUT AVE KENSINGTON MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/19/89	Everly Crematory	Alexandria, Virginia
24. FUNERAL DIRECTOR (NAME) Everly-Wheatley Funeral Home	ADDRESS 1500 W. Braddock Rd. Alexandria, Virginia	25a. DATE REC'D BY REGISTRAR FEB 24 1989	25b. REGISTRAR'S SIGNATURE Julia Davidson-Mongeon

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

122928 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005589
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: JOE LEWIS PECORE			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 7 1989	2b. HOUR: 9:20 A M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JULY 27 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: U.S.NAVY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
DISTRICT OF	COLUMBIA	Washington	YES [ ] NO [ ]	418 CONSTITUTION AVENUE, NE 20002

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CHESTER WINTWORTH PECORE	GENEVA LEWIS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	1942-1980	544-05-3354	PEGGY L.PECORE,418 CONSTITUTION AVE.,NE, WASHINGTON, DC 20002

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): METASTATIC ADENOCARCINOMA

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 30 19 89 to FEBRUARY 7 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 7 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
R L Morrissey M.D.	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	8 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R. L. MORRISSEY, LCDR, MC, USN	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Feb.10,1989	Arlington National Cemetery	Arlington Co., Virginia

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
J.Wm.Lee's Sons Co.300-4th St.,NE,Wash.,DC20002	FEB 13 1989	Julia Davidson-Randall

BP

DHMH - 1650M 1/81 (VRA 15, 4)

124131 FEB 29 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 30

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005590

1. DECEASED NAME (TYPE OR PRINT) First: Mildred Middle: Emma Last: Peters			2a. DATE OF DEATH Month: 2 Day: 1 Year: 89	2b. HOUR: 2202 M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month: Sept. Day: 23 Year: 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: PG	13c. CITY OR TOWN: Temple Hills	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 2900 St. Clair Dr. # 405	20748
14. FATHER'S NAME First: Oscar Middle: Last: Shane ~~Share~~		15. MOTHER'S MAIDEN NAME First: Wilhelmina Middle: Last: Sattler ~~Sutter~~			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-46-7528	17. INFORMANT: Wayne E. Peters	ADDRESS: 8405 Seven Locks Rd. Beth., MD 20817	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	5 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Pulmonary Embolism	1 month
DUE TO, OR AS A CONSEQUENCE OF (c)	Deep Venous Thrombosis	uncertain

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cellulitis (L) foot - resolving, Obesity

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from January 23 19 89 to February 1 19 89, that (I) (we) last saw the deceased alive on February 1 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wayne L. Meyer	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/1/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wayne L. Meyer MD	22e. ADDRESS: 9715 Medical Center Drive #214, Rockville MD 20850		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-6-89	23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem.	23d. LOCATION CITY OR TOWN: Arl., VA	COUNTY / STATE
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc.	ADDRESS: 5130 WI Ave. NW Wash., DC 20016	25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall	

023661 FEB 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05591
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: RODNEY EUGENE PHEARSE, JR.			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 13 1989		2b. HOUR: 11:28 A M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 12 1989	6. AGE (IN YEARS LAST BIRTHDAY) YRS:	IF UNDER 1 YEAR MONTHS / DAYS: 1	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: VIRGINIA	13b. COUNTY: PRINCE WM.	13c. CITY OR TOWN: QUANTICO	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: P.O.BOX 417	22134
14. FATHER'S NAME FIRST MIDDLE LAST: RODNEY EUGENE PHEARSE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: SANDRA ANN GRIFFIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): –	16b. SOCIAL SECURITY NO.: N/A	17. INFORMANT ADDRESS: RODNEY E.PHEARSE,P.O.BOX 417,QUANTICO, VA		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURITY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 12 19 89 to FEBRUARY 13 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: David H Moore — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 16 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAVID MOORE, LT, MC, USN

22e. ADDRESS: NAVAL HOSPITAL, BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): RELEASED TO HOSPITAL	23b. DATE: 16 Feb 89	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Taylor Rudasill

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, the medical examiner must be notified by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

24153 FEB 29 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05592
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 110

DHMH - 1650M (/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Margaret	MIDDLE: B.	LAST: PHelps	2a. DATE OF DEATH MONTH: 2	DAY: 1	YEAR: 89
2b. HOUR: 10 10 AM M					
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: 10 DAY: 13 YEAR: 98	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:
IF UNDER 24 HRS. HOURS:	MIN.:				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BEAUTICIAN	12b. KIND OF BUSINESS OR INDUSTRY: JOSEPH PAIANO BEAUTY SHOP		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS: 1001 SPRING ST. #510 20910	
14. FATHER'S NAME FIRST: JOSEPH	MIDDLE: P.	LAST: BRADY	15. MOTHER'S MAIDEN NAME FIRST: KATHRYN	MIDDLE:	LAST: HARMON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579-05-1158	17. INFORMANT: DAUGHTER MARGARET P. SIMMS	ADDRESS: 9908 BRIXTON LANE BETHESDA, MD 20817	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiovascular collapse
DUE TO, OR AS A CONSEQUENCE OF (b): acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c): arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital) attended the deceased from 1984, 19__, to 2/1, 19 89, that (I) (we) last saw the deceased alive on 2/1, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph M. Solinas	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/1/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSEPH M. SOLINAS MD	22e. ADDRESS: 9801 GEORGIA AVE. S.S. Md 20902		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 4, 1989	23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM	23d. LOCATION CITY OR TOWN: SILVER SPRING	COUNTY: MONTGOMERY STATE: MD
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

023942 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05593
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: RICHARD	MIDDLE: L.	LAST: PHILLIPPI	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 14, 1989	2b. HOUR: 10:20pm	
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: 09 01 1928	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MONTGOMERY GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CRYPTOLOGIST	12b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: PRINCE GEO	13c. CITY OR TOWN: NEW CARROLLTON	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 6016 MENTANA STREET	20784
14. FATHER'S NAME FIRST: EDWARD	MIDDLE: F	LAST: PHILLIPPI	15. MOTHER'S MAIDEN NAME FIRST: LULA	MIDDLE	LAST: PICKLE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): KOREA	16b. SOCIAL SECURITY NO.: 229-32-6188	17. INFORMANT: MARTHA PHILLIPPI	ADDRESS: 6016 MENTANA STREET NEW CARROLLTON, MD	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart failure
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/11, 19 89, to 2/14, 19 89, that (I) (we) last saw the deceased alive on 2/14, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert Gold DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert L. Gold

22e. ADDRESS: 15225 Shady Grove Rd Rockville MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 2-17-89	23c. NAME OF CEMETERY OR CREMATORY: SEAVER CREMATORIUM	23d. LOCATION CITY OR TOWN: PRINCETON	COUNTY: WEST VIRGINIA STATE
24. FUNERAL DIRECTOR NAME: SEAVER-BROWN FUNERAL SERV	ADDRESS: MARION, VIRGINIA	25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

0230209 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05594
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it completely filled in by the funeral director, page 1 and 2 should be filed within 72 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Edward Francis PLANT			2a. DATE OF DEATH MONTH DAY YEAR: 2-2-89	2b. HOUR: 1150 A M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: September 21, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Marine Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Boat Industry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Hyattsville	YES [X] NO [ ]	5613 Randolph Street 20784

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Irving D. Plant	Nannie H. Wissman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife)	
Yes-Army	WWII	321-12-0909	Dorothy Plant	5613 Randolph Street Hyattsville, Maryland 20784

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE) (a) Cardiopulmonary failure
DUE TO, OR AS A CONSEQUENCE OF: (b) Prostate problems
DUE TO, OR AS A CONSEQUENCE OF: (c) Pain in bones
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/13 19 89, to 2/2 19 89, that (I) (we) last saw the deceased alive on 1/31 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Lewis H. Dennis M.D. DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Lewis H. Dennis, M.D.

22e. ADDRESS: 6201 Greenbelt Road, #U-17 College Park, Maryland 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/06/89	Fort Lincoln Cemetery	Brentwood P.G. Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR: FEB 9 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023384 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05595 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 20

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: WANDA	MIDDLE	LAST: POKINSKI	2a. DATE OF DEATH MONTH DAY YEAR: 1-31-89	2b. HOUR: 2:40 PM
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: MARCH 26 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSP.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [X]	1516 MENLEE DRIVE 20904

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
IGNACY / / BIENIECKI	PRAKCEDA / / ZIELINSKI	NO	106-12-4639	JOSEPH N. POKINSKI/HUSBAND/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE, INTRA CEREBRAL BLEEDING
DUE TO, OR AS A CONSEQUENCE OF (c) MALIGNANT HYPERTENTION
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-29-19 89 to 1-31-19 89, that (I) (we) last saw the deceased alive on 1-31-19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE, DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
S. Sudhakar, M.D	[ ] [X] [ ]	1-31-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SWAROOP SUDHAKAR	50W EDMONSTON DR., ROCKVILLE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 3, 1989	ARLINGTON NATIONAL CEM.	ARLINGTON VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 01 '89	Julia Davidson-Randall

021828 FEB-6 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05596
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DOROTHY MIDDLE:	LAST: POLLACK	2a. DATE OF DEATH MONTH: 2 DAY: 1 YEAR: 89	2b. HOUR: 8:45 AM	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: 10 DAY: 9 YEAR: 13	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MINNESOTA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	11700 Old Columbia Pike, #319 (20904)

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Morris / Bloom	Sarah / Michlin	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	----------	577-05-3699	Harry Pollack; Husband;	#319; 11700 Old Columbia Pk. Silver Spring, Md. 20904

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardiorespiratory arrest	1 minute
DUE TO, OR AS A CONSEQUENCE OF (b)	endometrial cancer	54 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from November 19 87, to February 1 19 89, that (I) (we) last saw the deceased alive on February 1 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
Bruce A. Silver	MD		2/11/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
BRUCE A. SILVER, M.D.	2101 Medical Park Drive, Suite 211; Sil.Spg., Md. 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/3/89	Mt. Lebanon Cemetery	Adelphi; P.G.; Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS; 1170 Rockville Pike; Rockville, Md. 20852	FEB 3 1989	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024144 FEB 29 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05597 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST: PEDRO; MIDDLE: A.; LAST: PORRO, Sr.	2a. DATE OF DEATH — MONTH: 2; DAY: 2; YEAR: 89	2b. HOUR: 12 20 AM		
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH — MONTH: 8; DAY: 28; YEAR: 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Cuba	7b. CITIZEN OF WHAT COUNTRY?: Cuba	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Journalist	12b. KIND OF BUSINESS OR INDUSTRY: Newspaper	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) — 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS: 4521 East-West Highway/20814
14. FATHER'S NAME — FIRST: Pedro; MIDDLE; LAST: Porro		15. MOTHER'S MAIDEN NAME — FIRST: Maria; MIDDLE; LAST: Pina		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 579-70-1580	17. INFORMANT — ADDRESS: Mrs. Bertha M. Lastre, Daughter, 18764 Olney Mill Road, Olney, Maryland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): KIDNEY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: YEARS
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SEIZURE DISORDER, ANEMIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/1 19 87 to 2/2 19 89, that (I) we) last saw the deceased alive on 2/1 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph Nuboan	DEGREE: M.D.	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/2/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): RALPH COAN M.D.	22e. ADDRESS: 4400 EAST WEST HWY BETHESDA, Md. 20814		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Entombment	23b. DATE: Feb. 3, 1989	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery Mausoleum	23d. LOCATION — CITY OR TOWN: Silver Spring; COUNTY; STATE: Maryland	
24. FUNERAL DIRECTOR (NAME): Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD. 20814		25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

025352 MAR 16 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005598 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: LEONARD G. PORTER			2a. DATE OF DEATH MONTH DAY YEAR: 2 18 89	2b. HOUR: 4:09 PM
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: SEPT 21 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BATTALION CHIEF	12b. KIND OF BUSINESS OR INDUSTRY: DC FIRE DEPT.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES ☐ NO ☐	10506 AMHERST AVE 20902

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
STEPHEN M. PORTER	SARAH GUTRIDGE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	214-36-4348	LUCILE P. PORTER/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory arrest	48hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Ruptured Abdominal Aortic Aneurysm	2 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Abdominal Aortic Aneurysm	unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hepato renal syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/25/89	Ruptured Aortic Aneurysm	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from JAN 25 19 89 to FEB 18 19 89, that (I) (we) last saw the deceased alive on FEB 18 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GARRY D. RUBEN	11120 New Hamp Ave SS, Md 20904

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	FEB 20, 1989	METROPOLITAN CREMATORY	ALEXANDRIA VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 22 '89	Julia Davidson-Randall

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

023361 FEB 2265

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1a. FOR STATE REGISTRAR 89 — REG. NO. 05599

1. DECEASED NAME (TYPE OR PRINT): FIRST Francis; MIDDLE Wayne; LAST Potts Jr.

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — MONTH Jan DAY 28 YEAR 1989 — HOUR 9:14 AM

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH DAY YEAR June/30/1947 — 6. AGE (IN YEARS LAST BIRTHDAY): 41 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR Jan 28 1989 — HOUR 9:30 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Account Executive

12b. KIND OF BUSINESS OR INDUSTRY: Broadcasting

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Silver Spg — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 2445 Lyttonsville Rd. / 20910

14. FATHER'S NAME: FIRST Francis; MIDDLE Wayne; LAST Potts, Sr.

15. MOTHER'S MAIDEN NAME: FIRST Gladys; MIDDLE S.; LAST Schellin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): Vietnam

16b. SOCIAL SECURITY NO.: 578-64-9278

17. INFORMANT: Deborah W. Potts — ADDRESS: Same as # 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Inf.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).: None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers — TITLE (SPECIFY) M.D. Dep. Chief MEDICAL EXAMINER — DATE SIGNED Jan 28 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers — ADDRESS: 1919 Seminary Rd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Jan. 31, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — 23d. LOCATION CITY OR TOWN: Suitland — COUNTY: P.G. Co. — STATE: Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert E. Wilhelm, Inc, Suitland, Maryland

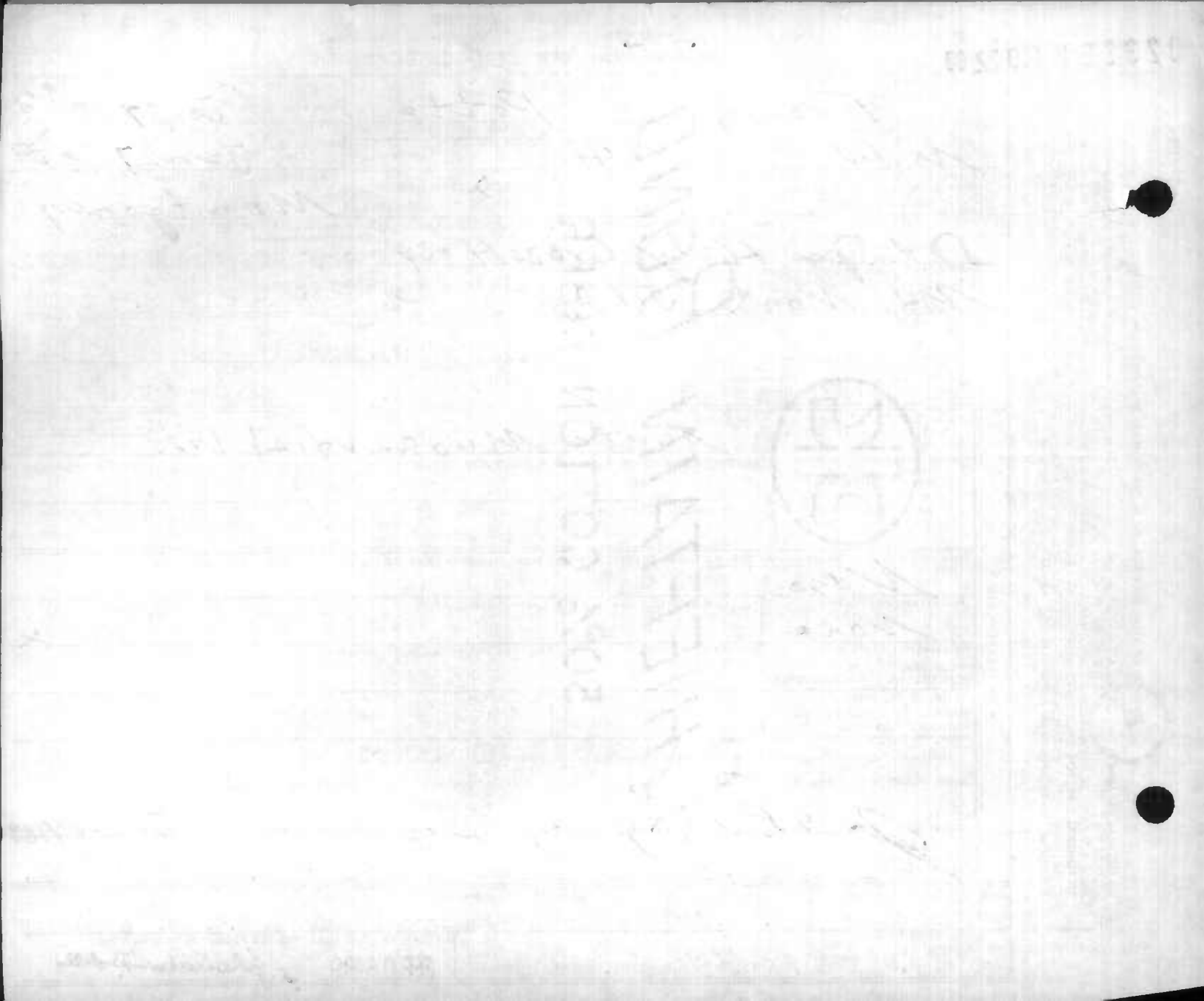
25a. DATE REC'D. BY REGISTRAR: FEB 06 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

08/84 25M BP 6

DHMH - 17
(VR A15 ME (5))



025376 MAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 005600

1. DECEASED NAME (TYPE OR PRINT): FIRST JOSEPH, MIDDLE B., LAST POWELL, SR.
Joseph B Powell Sr.

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH Feb DAY 15 YEAR 1989
2b. HOUR OF DEATH 1:30 P.M.
2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 15 YEAR 1989
2d. HOUR PRONOUNCED DEAD 1:42 P.M.

3. SEX: M
4. RACE: W1
5. DATE OF BIRTH: MONTH 06 DAY 8 YEAR 1907
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.
IF UNDER 1 YR.: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spg.
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 613 Blick Dr.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Store Mngr/
12b. KIND OF BUSINESS OR INDUSTRY: Liquers

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Mont.
13c. CITY OR TOWN: Silver Spg.
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 613 Blick Dr.

14. FATHER'S NAME: FIRST Frederick MIDDLE LAST Powell
15. MOTHER'S MAIDEN NAME: FIRST Emma MIDDLE LAST Behrens

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES): N/A
16b. SOCIAL SECURITY NO.: 578 03963
17. INFORMANT ADDRESS: Mary B. Powell-wife-(same as 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarct
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER DATE SIGNED: Feb. 15 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, DME ADDRESS: 1919 Seminary Rd. S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-18-1989
23c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
23d. LOCATION CITY OR TOWN: Washington COUNTY: DC STATE:

24. FUNERAL DIRECTOR NAME: Hines/Rinaldi Funeral Home ADDRESS: 11800 N.H. Ave., Silver Spring, Md.
25a. DATE REC'D. BY REGISTRAR: FEB 21 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITE ON THE LINE RECORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 FOR BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP 4 DHMH - 17 (VR A15 ME (5))

023933 FEB 28 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05601
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: JEWELL	MIDDLE: M.	LAST: PRATHER-ADAMS	2a. DATE OF DEATH MONTH: 2	DAY: 18	YEAR: 89
2b. HOUR: 1408 M					
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: 6	DAY: 20	YEAR: 40	6. AGE (IN YEARS LAST BIRTHDAY): 48 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADVENTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): INSPECTOR	12b. KIND OF BUSINESS OR INDUSTRY: MONT. CO. GOV.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: M.D.	13b. COUNTY: P.G.	13c. CITY OR TOWN: CAPT HTS.	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 5213 DOPPLER STREET 20743	
14. FATHER'S NAME FIRST: JAMES	MIDDLE:	LAST: PERRY	15. MOTHER'S MAIDEN NAME FIRST: MATTIE	MIDDLE:	LAST: DUNSTOR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-38-5325	17. INFORMANT: JESSE ADAMS	ADDRESS: 5213 DOPPLER STREET CAPT, HTS. MARYLAND	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia (mucormycosis)
DUE TO, OR AS A CONSEQUENCE OF (c): GI bleeding, cirhosis, and renal failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hepatic encephalopathy, hyperbilirubinemia, varices, mucormycosis, gastritis, coagulopathy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/2/88, 19__, to 2/18/89, 19__, that (I) (we) last saw the deceased alive on 2/18/89, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mary Fang, MD	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/18/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Mary Fang, MD	22e. ADDRESS: 10931 Mockingale Ct. Potomac, Md. 20854		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-23-89	23c. NAME OF CEMETERY OR CREMATORY: HARMONY CEMETERY	23d. LOCATION CITY OR TOWN: LANDOVER COUNTY: P.G. STATE: M.D.
24. FUNERAL DIRECTOR NAME / ADDRESS: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C.	25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024818 MAR -7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05602 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Edward MIDDLE STEDMAN LAST Prescott Jr

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH Feb DAY 8 YEAR 89

2b. HOUR 11:47 A.M.

3. SEX: M

4. RACE: White

5. DATE OF BIRTH: MONTH Jan DAY 12 YEAR 1969

6. AGE (IN YEARS LAST BIRTHDAY): 19 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 8 YEAR 1989

2d. HOUR 11:47 A.M.

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp

12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): ATTORNEY

12b. KIND OF BUSINESS OR INDUSTRY: LAW

USUAL RESIDENCE (OF DECEDENT, WHETHER INSTITUTION OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: AA

13c. CITY OR TOWN: ANNAPOLIS

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 867 CLUBHOUSE Village View 21401

14. FATHER'S NAME: FIRST EDWARD MIDDLE STEDMAN LAST PRESCOTT

15. MOTHER'S MAIDEN NAME: FIRST CAHLANDER MIDDLE MINNICK LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 217 14 5119

17. INFORMANT: Joycelyn S. Prescott ADDRESS: #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Dis.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Myocardial Dis.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Robert L Rogers, M.D. TITLE (SPECIFY): Dep MEDICAL EXAMINER

DATE SIGNED: Feb 8, 1989

EXAMINER'S NAME (TYPE OR PRINT): ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: 2/9/89

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION CITY OR TOWN: Alex COUNTY: Fairfax STATE: Va.

24. FUNERAL DIRECTOR NAME: Taylor Funeral Chapel ADDRESS: Annapolis, MD.

25a. DATE REC'D. BY REGISTRAR: FEB 10 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M

BP 18+1

DHMH - 17 (VR A15 ME (5))

022609 FEB 14 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05603
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Margaret	Freda	Pyle	February	7	89	1810 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
Female	White	August 21, 1922	66 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		Montgomery Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Shady Grove Adventist Hospital	Teacher (Ret)	A.A.Bd. of Educ.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Gaithersburg	YES ☐ NO ☒	17829 Hazelcrest Dr. 20877

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Elmer		Miller, Sr.	Ethel		Hutchison

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Son) ADDRESS
No	-	185.18.0125	Nelson A. Pyle 123 Foxwell Bend Glen Burnie, Md. 21061

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Ventricular arythmia	sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	ischemic heart disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
E. coli sepsis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2/7, 1989, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John R. Melnick	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Melnick	911 Russell Ave. Gaithersburg Md 20879

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	Feb. 12, 1989	Security Process, Inc.	Catonsville Balto. Maryland

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Singleton Funeral HOme, Glen Burnie, Maryland	FEB 10 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

24152 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 056 04 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: THUYEN	MIDDLE: Nhu	LAST: Quan	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ]	MONTH: 1/31 DAY: 19 YEAR: 89
2b. HOUR OF DEATH	M				
3. SEX	Female	4. RACE	Oriental	5. DATE OF BIRTH	MONTH DAY YEAR: Dec. 26, 1899
6. AGE (IN YEARS LAST BIRTHDAY)	89 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR: 1/31 19 89
2d. HOUR OF PRONOUNCED DEAD	3:11 P. M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	CHINA	7b. CITIZEN OF WHAT COUNTRY?	CHINA	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH	Silver Spring	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	10204 McKenney Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES [ ] NO [ ]	10204 McKenney Avenue 20902

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
KHIEN		QUAN	CHE		LY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		576-33-1108	PHAT ICH KHONG/SON/SAME AS 13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial disease.	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
None		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
		None

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: John S. Rogers

TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER

DATE SIGNED 2/1/89

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.

ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	FEB 1,1989	METROPOLITAN CREMATORY	ALEXANDRIA VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 06'89	Julia Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025363 MAR 16 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005605
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: JOSEPH ELBERT QUILLEN			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 16 1989	2b. HOUR: 7:30 AM
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: DECEMBER 1 1916	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED (CAPT)	12b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	CHEVY CHASE	YES [X] NO [ ]	8824 BRIERLY ROAD 20815

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
ELBERT MARTIN QUILLEN	NANCY ELLEN OSBORNE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	1939-1948	217-42-8745	GERTRUDE QUILLEN, 8824 BRIERLY ROAD, CHEVY CHASE, MD 20815

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): PNEUMONIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): END STAGE PROSTATIC CANCER

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I **certify** that (I) (this hospital) attended the deceased from JANUARY 21 19 89 to FEBRUARY 16 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	16 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C. A. THOMPSON, LT, MC, USN	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-21-1989	ARLINGTON NAT'L. CEM.	ARLINGTON, ARL. CO., VA.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO. INC. SILVER SPRING, Md. 20910	FEB 22 '89	Julia Davidson-Randall

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

025294 MAR 14 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056 06
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES	MIDDLE: P.	LAST: QUINN, Sr.	2a. DATE OF DEATH MONTH: 02 DAY: 14 YEAR: 89	2b. HOUR: 6:40 PM	
3. SEX: MALE	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: 06 DAY: 01 YEAR: 13	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY County, MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant	12b. KIND OF BUSINESS OR INDUSTRY: Securities & Exchange Commission		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES [ ] NO [X]	13109 Superior Street/20853

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James	P.	Quinn	Anne		Green

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes		178-07-4319	Ruth C. Quinn	same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pneumonia - Organism undetermined — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Cerebral arteriosclerosis with numerous strokes / pseudobulbar palsy & Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from March 19 66 to 14 February 19 89, that ~~(I)~~ (we) last saw the deceased alive on 14 February 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (we) ~~(did)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE: John F. Gustafson, M.D. DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 14 February 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John F. Gustafson, M.D.
22e. ADDRESS: 5480 Wisconsin Avenue Chevy Chase, MD. 20815

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 17, 1989	Gate of Heaven Cemetery	Silver Spring / Maryland

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Rockville, Inc. ADDRESS: 300 West Montgomery Ave., Rockville, MD 20850

25a. DATE REC'D. BY REGISTRAR: FEB 16 '89
25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

BP 10+/gratt

DHMH - 1650M 1/81 (VRA 15, 4)

025379 MAR 16 89

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05607
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Isabel	Prichard	Radford	February 20, 1989	7:00 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Female	Caucasian	February 2, 1920	69 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington D.C.	United States		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Potomac	10310 Gary Road	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Potomac	YES ☐ NO X	10310 Gary Road/20854

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Walter		Prichard	Florence	May	Tolson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		579-12-9823	William Bruce Radford 7367 Hallmark Road Clarksville, Maryland 21029 (Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Disseminated Histoplasmosis	2 years
DUE TO, OR AS A CONSEQUENCE OF (b)	Acquired Immunodeficiency Syndrome	2 years
DUE TO, OR AS A CONSEQUENCE OF (c)	Blood Transfusion(Human Immunodeficiency Virus Contaminated)	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
Recurrent Small Bowel Obstruction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) XXXXXX attended the deceased from October 26, 19 88, to February 20, 19 89, that (I) XX last saw the deceased alive on February 17 19 89, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above. (I) XX (did) (XX) not view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Michael A. Sauri M.D.	ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	February 20, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Michael A. Sauri M.D.	9715 Medical Center Drive Suite 201 Rockville, Maryland 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	February 21, 1989	Potomac Methodist Church Cemetery	Potomac, Maryland

24. FUNERAL DIRECTOR NAME	7557 Wisconsin Avenue Bethesda, Maryland 20814	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.		FEB 21 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

DHMH - 16 60M 7/84
(VRA 15, 4)

022812 FEB 15 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056 03 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	First: Astrid (Astrid)	Middle: Florence (Florence)	Last: Ramsey (Ramsey)	2a. DATE OF DEATH Month/Day/Year: 2-8-89	2b. HOUR: 1030 PM
3. SEX: Female	4. RACE: CAUC	5. DATE OF BIRTH Month/Day/Year: 3 / 24 / 02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Stenographer		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Takoma Park	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 8116 Roanoke Ave. 20912	
14. FATHER'S NAME First: Charles	Middle: A.	Last: Okerlund	15. MOTHER'S MAIDEN NAME First: Elfreda	Middle: E.	Last: Anderson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): None	16b. SOCIAL SECURITY NO.: 141-24-9411	17. INFORMANT: Donald D. Ramsey	ADDRESS: 8116 Roanoke Ave. Takoma Park, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO, OR AS A CONSEQUENCE OF (b): Sepsis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hiatal Hernia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-13 19 89 to 2-8 19 89, that (I) (we) last saw the deceased alive on 2-8 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael N Peskin	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: Feb. 9 1989	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael N Peskin	22e. ADDRESS: 7610 Carroll Ave. Takoma Park, Md. 20912		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal	23b. DATE: Feb. 9, 1989	23c. NAME OF CEMETERY OR CREMATORY: George Washington	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Medical School Wash. D.C.	
24. FUNERAL DIRECTOR NAME: Columbia Mortuary Services ADDRESS: 225 Missouri Ave. N.W. Washington D.C. 20011	25a. DATE REC'D BY REGISTRAR: FEB 13 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

025279 MAR 14 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05609
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Robert	J	RanKin	Feb 15, 1989	5:15PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	Oct 30 1890	98 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
NEW YORK	USA	WIDOWED [X]	MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Colonial Villa Nsg. Center	STREET CAR DRIVER	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	WORCESTER	OCEAN CITY	YES [ ] NO [ ]	403 139TH STREET 21842

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
UNKNOWN		RANKIN	ISABELLA		UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		076-09-5137	JAMES L. RANKIN/GRANDSON/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Left lower lobe pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that ~~I~~ (this hospital) attended the deceased from May 1, 1980, to Feb. 15, 1989, that ~~I~~ (we) last saw the deceased alive on Feb 15, 1989, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I ~~saw~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Raymond Bradshaw Jr MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Raymond Bradshaw, MD	345 Univ. Blvd, W Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	FEB 16, 1989	METROPOLITAN CREMATORY	ALEXANDRIA VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 17 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner, either police or coroner, must be notified before any action is taken.

BP 3

DHMH - 16 60M 7/84
(VRA 15, 4)

025286 MAR 14 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056 10 — REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Venkatasubba /	/ Rao	2a. DATE OF DEATH MONTH DAY YEAR: Feb 14 1989 — 2b. HOUR: 3:30 PM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: February 20, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): India	7b. CITIZEN OF WHAT COUNTRY?: India	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Bridge Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES [ ] NO [X]	7820 English Way/20817

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Venkata / / Ramaiah	Meenakshamma

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		217-94-3052	Narendra Kumar, same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY FAILURE	30 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	OVERWHELMING SEPSIS - Group A β hem STREP	5 days
DUE TO, OR AS A CONSEQUENCE OF (c)	CELLULITIS OF LEFT HAND	7 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/9/89 2/10/89	GANGRENE OF HAND AND ARM	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/8/89, 19__, to 2/14, 19 89, that (I) (we) last saw the deceased alive on 2/14, 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Carol W Garvey	MD	[X] / [ ] / [ ]	2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CAROL W. GARVEY	11510 OLD GEORGETOWN ROAD ROCKVILLE, MD 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb. 15 1989	Montgomery Crematorium Inc	Bethesda, Maryland

24. FUNERAL DIRECTOR NAME, ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814	FEB 16'89	Julia Davidson-Randall

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

023177 FEB 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056111
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: DONALD ROBERT REDDEN			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 9 1989	2b. HOUR: 8:45 P M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: AUGUST 8 1916	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY	MD.
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: U.S.A.F.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
VIRGINIA	FAIRFAX	BAILEY'S CROSSROADS	YES [ ] NO [X]	5601 SEMINARY ROAD 22041

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
THOMAS REDDEN	ETHEL CRAIG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES 1939-1966	161-18-0855	DOROTHY J. REDDEN, 5601 SEMINARY ROAD, APT N2113, BAILEY'S CROSSROADS, VA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SMALL CELL CARCINOMA OF THE LUNG

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I **certify** that (I) (this hospital) attended the deceased from FEBRUARY 9, 19 89, to FEBRUARY 9, 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 9 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
R L Morrissey	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	10 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R. L. MORRISSEY, LCDR, MC, USN	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	2/15/'89	Arlington Nat. Cemetery	Arlington, Virginia

24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
COLONIAL FUNERAL HOME,	6161 Leesburg Pike, Falls Church, VA 22044	FEB 15 1989	Willie Davidson-Randall

BP

DHMH - 1650M 1-81 (VRA 15, 4)

025346 MAR 16 '89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005612 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Margaret	Middle: E	Last: Reisinger	2a. DATE OF DEATH Month: 2	Day: 19	Year: 89	2b. HOUR: 3:30 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month Day Year: May 7, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., DC	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.			
10. CITY OR TOWN OF DEATH: Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Nursing & Retirement Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Wash., DC	13b. COUNTY: N/A	13c. CITY OR TOWN: Wash.	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 1417 Kalmia Rd. NW 9999		
14. FATHER'S NAME First: William	Middle	Last: Miller	15. MOTHER'S MAIDEN NAME First: Mary	Middle	Last: Heine	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578-36-4445	17. INFORMANT: Carl H. Reisinger	ADDRESS: Same as item # 13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): arterio sclerotic heart disease with Chronic CHF

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2-19, 1989, that I (we) last saw the deceased alive on 2-16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) [ ] (did not) view the body after death.

22b. SIGNATURE: G. Sengstack / Ed Richards, M.D.	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2-19-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. George F. Sengstack	22e. ADDRESS: 3929 Ferrara Dr. Wheaton, MD 20906	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/21/89	23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cem.	23d. LOCATION CITY OR TOWN: Wash., DC / COUNTY / STATE
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 WI Ave. NW Wash., DC 20016	25a. DATE REC'D BY REGISTRAR: FEB 22 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 10

DHMH 16 50M 1/81 (VRA 15, 4)

D24139 FEB 29 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05613 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other [illegible] event, the medical examiner must be notified at once.

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Ina M. Rice				2a. DATE OF DEATH MONTH DAY YEAR: January 29, 1989	2b. HOUR: 7:00pm
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 1 1897		6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penn	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Baltimore City	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 8 Westbend Street	2/207
14. FATHER'S NAME FIRST / MIDDLE / LAST: James Pennell				15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Emma Mills	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217 26 3923		17. INFORMANT ADDRESS: 1820 Park Ave. Baltimore Md. James Rice (Son)	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure — years
DUE TO, OR AS A CONSEQUENCE OF (c): Renal Failure — uncertain
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Pneumonia - days

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/25/89, 19____, to 1/29/89, 19____, that (I) (we) last saw the deceased alive on 1/29/89 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Moseni	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1/29/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Covering for Watkins-Ferris MD Dr. Aikens	22e. ADDRESS: 3701 Rossmoor Blvd Silver Spring MD 20906		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/1/89	23c. NAME OF CEMETERY OR CREMATORY: Stevens Chapel	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Monroe Penn.	
24. FUNERAL DIRECTOR NAME / ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S.Md.		25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

025325 MAR 16 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2441

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005614

1. DECEASED NAME (TYPE OR PRINT) FIRST: DeLOISE	MIDDLE:	LAST: RIEGEL	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 4, 1989	2b. HOUR: 8:25PM	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: MARCH 30 1918	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 401 BELTON ROAD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES / NO X	13e. STREET ADDRESS: 401 BELTON ROAD 20901	
14. FATHER'S NAME FIRST: CLAUDE	MIDDLE: B.	LAST: SANFORD	15. MOTHER'S MAIDEN NAME FIRST: LOLA	MIDDLE: E.	LAST: FELTMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): 1942-1944	16b. SOCIAL SECURITY NO.: 579-09-1480	17. INFORMANT: DAUGHTER MARIAN J. THOMPSON	ADDRESS: 613 C 94TH STREET OCEAN CITY, MD 21842	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF:
(b):
DUE TO, OR AS A CONSEQUENCE OF:
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): coronary artery disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-30 19 89, to 2-4 19 89, that (I) (we) last saw the deceased alive on 1-30 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Donald L Bucy DEGREE: MD ATTENDING PHYSICIAN X / MEDICAL DIRECTOR / STAFF PHYSICIAN

22c. DATE SIGNED: 2-6-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Donald L Bucy SW Jones

22e. ADDRESS: 809 Veirs Mill Rd Rockville

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 8, 1989	23c. NAME OF CEMETERY OR CREMATORY: MARYLAND VETERANS CEM	23d. LOCATION CITY OR TOWN: CROWNSVILLE	COUNTY: ANNE ARUNDEL STATE: MD
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	25a. DATE REC'D. BY REGISTRAR: FEB 9 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

024158 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056 15

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. (Omit for removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALVINA	MIDDLE: E.	LAST: RIELAG	2a. DATE OF DEATH MONTH: 2	DAY: 3	YEAR: 89	2b. HOUR: 6:20P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 2	DAY: 25	YEAR: 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.			
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Potomac	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 12400 Goldfinch Ct. 20854		
14. FATHER'S NAME FIRST: Joseph	MIDDLE	LAST: Korte	15. MOTHER'S MAIDEN NAME FIRST: Anne	MIDDLE	LAST: Blaszer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 300-09-6892	17. INFORMANT ADDRESS: Audrey Peelman 12400 Goldfinch Ct. Potomac, Md 20854			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	15'
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Thrombosis	2 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic C-V disease	15 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/1/79 to 2/3/89, that (I) (we) last saw the deceased alive on 2/3/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen N. Jones	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/4/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen N. Jones	22e. ADDRESS: 809 Viers Mill Road Rockville, Md. 20852		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/7/1989	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven	23d. LOCATION CITY OR TOWN: Kenwood	COUNTY: Hamilton	STATE: Ohio
24. FUNERAL DIRECTOR NAME AND ADDRESS: Tyson Wheeler Funeral Home, Inc. 1331 Rockille Pike Rockville, Maryland 20852	25a. DATE REC'D. BY REGISTRAR: FEB 08 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall			

BP 5

DHMH - 16 60M 7/84
(VRA 15, 4)

Itm #'s 6,8, Film G6493/29/89cg

FOR 1- STATE REGISTRAR per Randy Brooks

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005616

023948 FEB 28 89

DECEASED NAME (TYPE OR PRINT): Wilhelmina Ring

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ — MONTH 2 DAY 20 YEAR 89

2b. HOUR: M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH March DAY 18 YEAR 1918

6. AGE (IN YEARS): 70 ~~89~~ IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 20 YEAR 89

2d. HOUR: 9:00P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED XX

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Olney

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3230 Spartan Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Olney

13d. INSIDE CITY LIMITS? YES ☐ NO XX

13e. STREET ADDRESS: 3230 Spartan Road 20832

14. FATHER'S NAME: William Cranmer

15. MOTHER'S MAIDEN NAME: Grace Baker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-48-2908

17. INFORMANT: Nan Ring Russum ADDRESS: 74 Morningside Keansburg, NJ 07734

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary thromboembolism

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Bilateral deep leg vein thrombosis

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Morbid Obesity

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Mario F. Golle Jr. M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-21-89

EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr., M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 23 1989

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION CITY OR TOWN: Arlington COUNTY: Virginia STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: Ives-Pearson Funeral Homes 2847 Wilson Blvd., Arlington, Va.

25a. DATE REC'D. BY REGISTRAR: FEB 23 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024209 FEB 29 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05617

REG. NO.

FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): First: Myrtle Middle: C Last: Riser

2a. DATE OF DEATH: Month 2 Day 20 Year 89

2b. HOUR: 0405 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Month Nov Day 6 Year 1906

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Georgia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): GSI Supervisor

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Mont.

13c. CITY OR TOWN: Brookeville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 20921 New Hampshire Avenue 20833

14. FATHER'S NAME: First Thomas Middle Last Acree

15. MOTHER'S MAIDEN NAME: First Katie Middle Last Callaway

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 579 26 4113

17. INFORMANT ADDRESS: 3424 Canbella St. S.S.Md.
Jacqueline Ruggieri (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial Ca -

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/20 19 89 to 2/20 19 89 that (I) (we) last saw the deceased alive on 2/20 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jeffrey Garris

22e. ADDRESS: 7110 Carroll Ave # 21 Takoma

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/23/89

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION: CITY OR TOWN: Brentwood COUNTY: PG STATE: Md.

24. FUNERAL DIRECTOR: NAME Hines/Rinaldi ADDRESS 11800 New Hamp. Ave. S.S.Md.

25a. DATE REC'D BY REGISTRAR: FEB 23 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

021937 FEB 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056 18
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: DAVID CURTIS ROBERDS			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 2 1989		2b. HOUR: 9:20 P M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: MAY 11 1920	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): OHIO	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: U.S.NAVY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [X]	905 WINHALL WAY 20904

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
DAVID CARSON ROBERDS	ELMA CATHERINE GRIFFITH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife) ADDRESS
YES	1941-1961	272-18-9929	BETTY J. ROBERDS, 905 WINHALL WAY, SILVER SPRING, MD 20904

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC MALIGNANT SPINDLE CELL CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
[ ]					

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 17 19 88 to FEBRUARY 2 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
William L Dahut	MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]	3 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
W.L.DAHUT, LT, MC, USNR	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/7/89	Arlington Cemetery	Arlington, Va.

24. FUNERAL DIRECTOR: Hines/Rinaldi 11800 New Hamp. Ave. S.S.Md.

25a. DATE REC'D. BY REGISTRAR: FEB 6 1989

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

023251 FEB 21 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 056 19
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: JEANE ELEANOR ROBERTS			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 13 1989	2b. HOUR: 11:57 A M	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: AUGUST 6 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): IOWA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY:	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
VIRGINIA	FAIRFAX	ALEXANDRIA	YES [ ] NO [X]	7770 THRUSH COURT	22306

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
CORNELIUS JASPER MUILENBURG	NELLIE NOTEBOOM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 470-12-2318	17. INFORMANT ADDRESS: KENNETH W.ROBERTS,SR.,7770 THRUSH COURT, ALEXANDRIA, VA 22306

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 30 19 89, to FEBRUARY 13 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
D.B. Robinson M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]	14 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
D. B. ROBINSON, LCDR, MC, USN	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	2/16/89	NORTHERN VIRGINIA CREMATORY	ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA	FEB 17 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - T6 50M 1/81 (VRA 15, 4)

023388 FEB 22 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05620 — REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: INEZ	MIDDLE: H.	LAST: ROBINSON	2a. DATE OF DEATH MONTH DAY YEAR: JANUARY 29, 1989	2b. HOUR: 6:05 PM	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: OCT. 28, 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): KANSAS	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 13511 ORIENTAL STREET	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): STOREKEEPER	12b. KIND OF BUSINESS OR INDUSTRY: DEPT STORE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: ILLINOIS	13b. COUNTY: ST. CLAIR	13c. CITY OR TOWN: BELLEVILLE	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 4132 LEBANON AVENUE 62221	
14. FATHER'S NAME FIRST: RICHARD	MIDDLE	LAST: INSLEY	15. MOTHER'S MAIDEN NAME FIRST: LUVINA	MIDDLE	LAST: HILLIARY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 496-36-9621	17. INFORMANT: DAUGHTER	ADDRESS: 13511 ORIENTAL ST.	
			PATRICIA PORTER	ROCKVILLE, MD 20853	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary insufficiency — 1 yea

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic obstructive lung disease — 10 year

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept 15 19 88 to 1-29 19 89, that (I (we) last saw the deceased alive on JAN. 16 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1-30-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): [illegible] 4730 Cameron St Silver Spring MD 20910

22e. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 2, 1989	23c. NAME OF CEMETERY OR CREMATORY: LAKEVIEW MEM CEM	23d. LOCATION CITY OR TOWN: BELLEVILLE	COUNTY: ST. CLAIR STATE: IL
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH-16 50M 1/81 (VRA 15, 4)

023369 FEB 22 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05621 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Margaret	MIDDLE: C.	LAST: Roedel	2a. DATE OF DEATH MONTH: 1	DAY: 28	YEAR: 89
2b. HOUR: 345 A M					
3. SEX: F	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: May DAY: 9 YEAR: 1889	6. AGE (IN YEARS LAST BIRTHDAY): 99 YRS	IF UNDER 1 YEAR MONTHS:	DAYS:
IF UNDER 24 HRS HOURS:	MIN.:				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 11005 Nicholas Drive 20902	
14. FATHER'S NAME FIRST: Preston	MIDDLE:	LAST: Smith	15. MOTHER'S MAIDEN NAME FIRST: Rosa	MIDDLE:	LAST: Covely
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 200-26-0622	17. INFORMANT: Marie C. Franetzki	ADDRESS: Daughter Same as 13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HYPOVOLEMIC AND SEPTIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF (b) ANEMIA, DEHYDRATION, SEPSIS
DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA, DECUBITUS ULCER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
INFECTED SKIN CANCER

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11 26 19 89, to 1 1 28 19 89, that (I) (we) last saw the deceased alive on 1 1 28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Tipaporn Woodward	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1 1 28 1 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): TIPAPORN WOODWARD	22e. ADDRESS: ~~5006~~ 5330 WISCONSIN AVE #550		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Jan. 30, 1989	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN: Silver Spring COUNTY: Montgomery STATE: Md.
24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. ADDRESS: 500 University Blvd., W. Silver Spring, Md. 20901		25a. DATE REC'D. BY REGISTRAR: JAN 30 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024147 FEB 29 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05622 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN	MIDDLE: (none)	LAST: RODAK, SR	2a. DATE OF DEATH MONTH DAY YEAR: FEB. 04 1989	2b. HOUR: 8:41 AM	
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 31, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Maint.Man	12b. KIND OF BUSINESS OR INDUSTRY: Kimberly-Clark		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 12503 Village Sq.Terr. #302	20852
14. FATHER'S NAME FIRST: John	MIDDLE:	LAST: Rodak	15. MOTHER'S MAIDEN NAME FIRST: Julianna	MIDDLE:	LAST: Pendel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 072-07-3278	17. INFORMANT ADDRESS: John Rodak Jr. 11606 Bunnell Ct. Potomac, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	ISCHEMIC CARDIOVASC. DISEASE	UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): RENAL CELL CARCINOMA.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan 22, 19 89, to Feb 4, 19 89, that (I (we) last saw the deceased alive on Feb 3, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/4/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Malcolm I. Cocking	22e. ADDRESS: 10101 Veirs Mill Rd. Wheaton, Md. 20902		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 8, 1989	23c. NAME OF CEMETERY OR CREMATORY: Riverdale Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Niagara Falls, New York	
24. FUNERAL DIRECTOR NAME: James E. DeVol	ADDRESS: DeVol Funeral Home 2222 Wisc, Ave, NW Wash. DC	25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

0240666 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 05623

1. DECEASED NAME (TYPE OR PRINT) FIRST: SARA MIDDLE: LAST: ROLNICK.			2a. DATE OF DEATH MONTH DAY YEAR: 2-18-89	2b. HOUR: 9:00 A M	
3. SEX: Female	4. RACE: caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 12-15 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): RUSSIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME OF GREATER WASH.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BUSINESS OWNER	12b. KIND OF BUSINESS OR INDUSTRY: RETAIL CLOTHING		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: MONTG.	13c. CITY OR TOWN: ROCKVILLE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 6121 MONTROSE RD. 20852	
14. FATHER'S NAME FIRST: DAVID MIDDLE: LAST: TOLSTOI		15. MOTHER'S MAIDEN NAME FIRST: ESTHER MIDDLE: LAST: NIMETZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): N/A.	16b. SOCIAL SECURITY NO.: 577-38-2578	17. INFORMANT: ROBERT ROLNICK	ADDRESS: 6912 ARMAT DR. BETHESDA MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary arrest	sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Pneumonia severe	days
DUE TO, OR AS A CONSEQUENCE OF (c)	severe Demented	years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-24-89 to 2-18-89, that (I) (we) last saw the deceased alive on 2-18-89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Loreto S. Albiol MD	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-15-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LORETO S. ALBIOL		22e. ADDRESS: 6121 MONTROSE RD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-20-89	23c. NAME OF CEMETERY OR CREMATORY: ADAS ISRAEL CEM.	23d. LOCATION CITY OR TOWN: WASHINGTON, D.C. COUNTY / STATE	
24. FUNERAL DIRECTOR NAME / ADDRESS: DANZANSKY-GOLDBERG MEM. CHPS. INC. 1170 ROCKVILLE PK. ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

023756 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005624
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: VICTOR	MIDDLE	LAST: ROSE	2a. DATE OF DEATH MONTH: 2 DAY: 17 YEAR: 89	2b. HOUR: 12:20 PM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 09 DAY: 17 YEAR: 00	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): RUSSIA	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): MERIDIAN NURSING & REHABILITATION CENTER	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): SALESMAN	12b. KIND OF BUSINESS OR INDUSTRY: INSURANCE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: KENSINGTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 3902 SPRUELL DRIVE 20895
14. FATHER'S NAME FIRST: HYMAN	MIDDLE	LAST: ROSE	15. MOTHER'S MAIDEN NAME FIRST: GOLDIE	MIDDLE / LAST: HYMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 231 10 0219A	17. INFORMANT: MILDRED ROSE,	ADDRESS: 3902 SPRUELL DRIVE KENSINGTON, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	METASTATIC CARCINOMA	2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (b)	CARCINOMA PROSTATE	8 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from JAN 26, 19 89, to FEB 17, 19 89, that (I) (we) last saw the deceased alive on JAN 21, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Hubert J. Albert DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): HUBERT J. ALBERT 22e. ADDRESS: 863 FENTON ST SILVER SPRING, MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/19/1989	23c. NAME OF CEMETERY OR CREMATORY: JUDEAN MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN: OLNEY COUNTY: MONTGOMERY STATE: MARYLAND	
24. FUNERAL DIRECTOR NAME: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME ADDRESS: 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D BY REGISTRAR: FEB 22 1989	25b. REGISTRAR: [signature]	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023180 FEB 17 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056 25 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harry	MIDDLE	LAST: Rubenstein	2a. DATE OF DEATH MONTH: 2 DAY: 12 YEAR: 89	2b. HOUR: 3:45 AM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: 10 DAY: 20 YEAR: 06	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.	
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY: Clothing Stor	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: -------	13b. COUNTY: --------	13c. CITY OR TOWN: Washington, DC	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 1443 Sheridan St., N.W., #303 (20011)
14. FATHER'S NAME FIRST: Moshe MIDDLE: LAST: Rubenstein		15. MOTHER'S MAIDEN NAME FIRST: (Unknown) MIDDLE: LAST:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Unknown	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 578-46-0022A	17. INFORMANT ADDRESS: #406; Chevy Chase, Md. 20815	Shraga Kawior, Esquire; 6900 Wisconsin Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Intracranial Hypertension

DUE TO, OR AS A CONSEQUENCE OF (c): Multiple cerebral infarcts

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6-27 19 89 to 2-12 19 89, that (I) (we) last saw the deceased alive on 2-12 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Daniel A. Jaller DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-12 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Daniel A. Jaller 22e. ADDRESS: 19511 Doctors Dr, Germantown, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/15/89	23c. NAME OF CEMETERY OR CREMATORY: BETH SHEMETH	23d. LOCATION CITY OR TOWN: JERUSALEM COUNTY: STATE: ISRAEL

24. FUNERAL DIRECTOR (NAME, ADDRESS): DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE: ROCKVILLE, MD

25a. DATE REC'D BY REGISTRAR: FEB 15 1989 25b. REGISTRAR'S SIGNATURE

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

23333 FEB 22 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005626

1. DECEASED NAME (TYPE OR PRINT) FIRST: Wilmer	MIDDLE: A.	LAST: Rusch	2a. DATE OF DEATH MONTH DAY YEAR: 02 03 89	2b. HOUR: 12:17AM	
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JUNE 21, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WISCONSIN	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): EXEC. DIRECTOR	12b. KIND OF BUSINESS OR INDUSTRY: INTERN. BRIDGE & TURNPIKE ASSOC.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [ ]	3318 ESTELLE TERRACE 20906

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
WILLIAM / / RUSCH	BERTHA / / PIEPENBURG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES WW II	395-10-9980	DORIS B. RUSCH WIFE SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO PULMONAR ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARRHYTHMIA

DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCT

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 3, 19 89, to FEBRUARY 3, 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 3, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Ernesto Malave	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]	2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ERNESTO MALAVE	18101 PRINCE PHILLIP DR. OLNEY, MD. 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB. 6, 1989	PARKLAWN CEMETERY	ROCKVILLE MONTGOMERY MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901	FEB 06 '89	Julia Davidson-Randell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 141

DHMH - 16 50M 1/81 (VRA 15, 4)

Cleared by Medical Examiner - Dr. Wehner

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

024605 1 MAR - 3 89 89 05627

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, unless otherwise directed within 72 hours after death.

DHMH - 16 3/72 25M (VR A15 (4))

1. DECEASED-NAME (Type or print)	First: Margaret	Middle: McQuade	Last: Sadler	2a. DATE OF DEATH: Month 02 Day 24 Year 1989	2b. HOUR: 4:45 PM
3. SEX: F	4. RACE: C	5. DATE OF BIRTH: 1 1 00	6. AGE (In years last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 602 Pershing Drive	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Mont.	13c. CITY OR TOWN: S.S.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 602 Pershing Drive 22910	
14. FATHER'S NAME First: Charles	Middle	Last: McQuade	15. MOTHER'S MAIDEN NAME First: Margaret	Middle	Last: McDonald
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N/A (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 132 05 5069	17. INFORMANT: Liz Golabart (Daughter) Same as 13/e			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 months
DUE TO, OR AS A CONSEQUENCE OF
(b): cardiomyopathy — 14 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Colon carcinoma - Duke's B

19a. DATE OF OPERATION: 6/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: colon carcinoma	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH ☐	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from January, 19 85, to Feb. 24, 19 89, that (I) (we) last saw the deceased alive on Feb. 24, 1989 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Susan Voss, MD DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/24/89	
22d. PHYSICIAN'S NAME (Type): SUSAN VOSS, MD	22e. ADDRESS: 10401 Old Georgetown Rd. Bethesda, Md. (Montgomery County)		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/27/89	23c. NAME OF CEMETERY OR CREMATORY: Long Island National	23d. LOCATION (City or Town) (County) (State): Farmingdale Suffolk N.Y.	
24. FUNERAL DIRECTOR: Hines/Rinaldi	ADDRESS: 11800 New Hamp. Ave. S.S. Md	25a. REC'D BY REGISTRAR DATE: MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024771 MAR 7 '89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05623 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Margaret	MIDDLE: Graham	LAST: Schaffer	2a. DATE OF DEATH MONTH: 02	DAY: 17	YEAR: 89
2b. HOUR: 5:28 AM					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 03 DAY: 04 YEAR: 15	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:
IF UNDER 24 HRS HOURS:	MIN.:				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Hyattsville	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 4114 Woodberry Street 20782	
14. FATHER'S NAME FIRST: Thomas	MIDDLE:	LAST: Graham	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE:	LAST: Davis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 214-42-3201	17. INFORMANT ADDRESS: (Husband) 4114 Woodberry Street Albert J. Schaffer Hyattsville, Md. 20782		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-16- 19 89, to 2-17 19 89, that (I) (we) last saw the deceased alive on ____ 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stanley Lugerner	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stanley Lugerner, M.D.	22e. ADDRESS: 2150 Penn. Ave. NW Washington, D.C. 20037		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 02/18/89	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory	23d. LOCATION CITY OR TOWN: Alexandria	COUNTY: Virginia
24. FUNERAL DIRECTOR ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

(30) BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

02 4705 MAR - 6 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

MARTHA L SALTER 2 9
REG. NO. 89 95 29

1. DECEASED NAME (TYPE OR PRINT) First: Martha Middle: L Last: Salter			2a. DATE OF DEATH Month: 2 Day: 27 Year: 89	2b. HOUR 835P M	
3. SEX: Female.	4. RACE: White.	5. DATE OF BIRTH Month: Oct. Day: 21 Year: 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Minn/	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery. MD.		
10. CITY OR TOWN OF DEATH: Takoma Park.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home maker.	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: P. G. Co.	13c. CITY OR TOWN: Adelphi	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 2712 Curry Dr.	20783
14. FATHER'S NAME First: Frank Middle: Newton. Last:		15. MOTHER'S MAIDEN NAME First: Ella Middle: Last: Not Available.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No. (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 479-10-7748	17. INFORMANT: Arlene Brown.	ADDRESS: (13 e)		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute GI Bleed - Upper & Lower — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Day.
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Hyperglycemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital) attended the deceased from 2/27 19 89 to 2/27 19 89 that (I) (we) last saw the deceased alive on 2/27 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: David Cromwell M.D. — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/28/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): David Cromwell — 22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL: Burial.	23b. DATE: Mar. 3, 1989	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill	23d. LOCATION CITY OR TOWN: Suitland, COUNTY: P. G. Co, STATE: Md.
24. FUNERAL DIRECTOR: Takoma Funeral Home.	ADDRESS: 254 Carroll St. N. W. D. C.	25a. DATE REC'D BY REGISTRAR: MAR 2 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 SOM 1/81 (VRA 15, 4)

024165 FEB 29 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05630 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Charles	MIDDLE: C.	LAST: Sanborn	2a. DATE OF DEATH MONTH DAY YEAR: January 30, 1989
2b. HOUR: 2:15 AM			
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: June 7, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.
10. CITY OR TOWN OF DEATH: Potomac	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Manor Care-Potomac	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Manager/ Supplies	12b. KIND OF BUSINESS OR INDUSTRY: Office & Furniture Store
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Potomac	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 9908 Logan Drive / 20854			
14. FATHER'S NAME FIRST: Merton	MIDDLE: C.	LAST: Sanborn	15. MOTHER'S MAIDEN NAME FIRST: Mary / MIDDLE: Elizabeth / LAST: English
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 577-07-1004	17. INFORMANT ADDRESS: Jean S. Nielsen, Daughter, Same as item #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio. Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Advanced Cancer of Prostate
DUE TO, OR AS A CONSEQUENCE OF (c): with Metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): —

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan. 1, 19 88, to Jan. 29, 19 89, that (I) (we) last saw the deceased alive on Jan. 1st 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: Jan 30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Azad Vosger, M.D. — 22e. ADDRESS: 10000 Falls Road Potomac, MD. 20854

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 2, 1989	23c. NAME OF CEMETERY OR CREMATORY: St. Gabriel's Cemetery	23d. LOCATION CITY OR TOWN: Potomac / COUNTY / STATE: Maryland	
24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ ADDRESS: Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR: JAN 31 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

025372 MAR 16 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 056311
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M

BP/0

DHMH - 17 (VR A15 ME (5))

1. DECEASED NAME (TYPE OR PRINT) FIRST: George (George) MIDDLE: S LAST: Sarvinas						2a. DATE KNOWN OF DEATH / ESTIMATED ☐: MONTH Feb DAY 20 YEAR 19 89	2b. HOUR 12:05 AM/PM
3. SEX: M	4. RACE: W	DATE OF BIRTH: MONTH April DAY 13 YEAR 08	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 20 YEAR 19 89	2d. HOUR 12:05 PM/PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Greece	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐				9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD	
10. CITY OR TOWN OF DEATH: Silver Spg	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Furrier	12b. KIND OF BUSINESS OR INDUSTRY: Self Employed
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: M	13b. COUNTY: Mont	13c. CITY OR TOWN: Silver Spg	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 11629 Lotwood Dr. Apt. 103			
14. FATHER'S NAME FIRST: Nicholas MIDDLE LAST: Sarvinas			15. MOTHER'S MAIDEN NAME FIRST: Eleftria MIDDLE LAST: Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 073 14 4046	17. INFORMANT ADDRESS: Savasti Sarvinas (Wife) Same as 13E				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(b): Chronic Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Double Harniorrhaphy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
Feb 16 1989	Double Inguinal Herniorrhaphy	YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Noturol causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Rogers M.D. TITLE (SPECIFY): Dep MEDICAL EXAMINER DATE SIGNED: Feb 25 1989

EXAMINER'S NAME (TYPE OR PRINT): Dr. John S. Rogers ADDRESS: 1919 Seminary Rd. S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/23/89	Gate of Heaven	Silver Spring Mont. Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New Hamp. S.S. Md.	FEB 21 '89	Julia Davidson-Randall

24159 FEB 29 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05632 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury, even if other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARGARET MIDDLE: S. LAST: SASSE			2a. DATE OF DEATH MONTH/DAY/YEAR: 2/4/89	2b. HOUR: 4:45 AM
3. SEX: FEMALE	4. RACE: Cauc.	5. DATE OF BIRTH MONTH/DAY/YEAR: 7/13/95	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Germany	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY Co. MD.	
10. CITY OR TOWN OF DEATH: Rockville M.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Collingswood Nsg. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOME MAKER	12b. KIND OF BUSINESS OR INDUSTRY: AT HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 10309 Cheshire Terrace 20814
14. FATHER'S NAME FIRST: Ferdinand MIDDLE: — LAST: Schmidt			15. MOTHER'S MAIDEN NAME FIRST: Louisa MIDDLE: LAST: SCHMIDT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 135-20-0573	17. INFORMANT: RICHARD C. SASSE	ADDRESS: 10309 CHESHIRE TERR. BETHESDA, Md. 20814	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Dehydration
DUE TO, OR AS A CONSEQUENCE OF (c): Fever of Unknown Origin

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-19, 19 81, to 2-4, 19 89, that (I) (we) last saw the deceased alive on 2-1-, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thos. J. Fuller MD for JAMES MOORE MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-4-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): TIBOR E. FRELKO — 22e. ADDRESS: 1921 Montgomery Village Ave Gaithersburg Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 2-7-1989	23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: RIVERDALE, PG.C., Md.	
24. FUNERAL DIRECTOR NAME: W.W. CHAMBERS CO. INC.	ADDRESS: SILVER SPRING, Md. 20910	25a. DATE REC'D. BY REGISTRAR: FEB 08 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

23523 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

File

89 005633

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: SHAWN DEAN SAVAGE, JR.			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 4 1989		2b. HOUR: 4:20 P M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: MAY 25 1987	6. AGE (IN YEARS LAST BIRTHDAY): 1 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DELAWARE	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: DELAWARE	13b. COUNTY: KENT	13c. CITY OR TOWN: DOVER	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: 509 BUCKSON DRIVE 19901	
14. FATHER'S NAME FIRST MIDDLE LAST: SHAWN DEAN SAVAGE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: TINA LYNNE WATERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: -	17. INFORMANT ADDRESS: SHAWN D. SAVAGE, 509 BUCKSON DRIVE, DOVER, DE		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): PENDING AUTOPSY RESULTS

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: FEB 3 1989	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: INTESTINAL MALROTATION	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 1 19 89, to FEBRUARY 4 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 4 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P W Stafford CDR MC	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 8 FEB 1989
22d. PHYSICIAN'S NAME (TYPED OR PRINT): P. W. STAFFORD, CDR, MC, USN	22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-11-89	23c. NAME OF CEMETERY OR CREMATORY: Eden	23d. LOCATION (CITY OR TOWN): Phila	STATE: Pa.
24. FUNERAL DIRECTOR NAME: Bennie Smith	ADDRESS: 1750 N. Dupont Dover, Del	25a. DATE REC'D. BY REGISTRAR: 2-13-89	25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of each.

BP 362

DHMH - 16 60M 7/84
(VRA 15, 4)

24138 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 39 9563 4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER (IF NOT WITH FORM PM 3). RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN X ESTIMATED ☐ MONTH	DAY	YEAR 19 89
Jean	Florence	Scaldaferri	1/29		

2b. HOUR —

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	Jun. 3, 1920	68 YRS.				

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 1/29 19 89

2d. HOUR: 10:37 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Italy	USA		Montgomery County MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	17520 St. Theresa Drive	Clerical	Hampshire Motor Inn

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS
Maryland	Montgomery	Olney		17520 St. Theresa Drive 20832

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Salvatore		Caruso	Antonina		Rascona

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A		578 23 5568	Chris Bartoli (Grandson)	15633 Ambiance Dr. Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial disease.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
None		YES ☐ NO X

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
		None

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry ☐, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1/30/89

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/2/89	Gate of Heaven	S.S.	Mont	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800	New Hamp. Ave, S.S. Md	FEB 01 '89	Julia Davidson-Randall

07/84 25M

BP 15

DHMH - 17 (VR A15 ME (5))

124669 MAR -3 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 REG. NO. 05635

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: LIESEL SCHUETZ SCHEIBER

2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 28 1989

2b. HOUR: 12:35 AM

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 27 1919

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GERMANY

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: BALTIMORE

13c. CITY OR TOWN: PERRY HALL

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 9919 MARILYNN ROAD 21128

14. FATHER'S NAME FIRST MIDDLE LAST: WILHELM HEINRICH SCHUETZ

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: ELISABETH DIETZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): -

16b. SOCIAL SECURITY NO.: 212-62-9633

17. INFORMANT ADDRESS: RUDOLPH T. SCHEIBER, 9919 MARILYNN ROAD, PERRY HALL, MD 21128

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): METASTATIC COLON CANCER

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 21 19 89 to FEBRUARY 28 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark S. Georgiadis

DEGREE: MD

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]

22c. DATE SIGNED: 2/28/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK S. GEORGIADIS, LT, MC, USNR

22e. ADDRESS: NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 3/3/89

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

23d. LOCATION CITY OR TOWN COUNTY STATE: ARLINGTON VIRGINIA

24. FUNERAL DIRECTOR: SCHLAMINEK FUNERAL HOME INC.

ADDRESS: 9705 Belair Rd., Baltimore, Md. 21236

25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989

25b. REGISTRAR'S SIGNATURE: Gisha Saunderson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024088 FEB 21 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 056356

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
SAVERIO	NMN	SCIACOVELLI	FEBRUARY	09	1989 / 12:53PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	07	01	31	57 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Italy	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NIH, THE CLINICAL CENTER	Owner/Operator	Delicatessen

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
NEW YORK	Bronx	New York	YES ☒ NO ☐	2302 LACONIA AVE, 10469

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Giacomo		Sciacovelli	Filomena		Colamonico

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	Korea	082-24-7891	MRS. YOLANDA SCIACOVELLI SAME AS DECEASED

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RECURRENT SUBDURAL HEMATOMA	3 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	DISSEMINATED INTRAVASCULAR COAGULATION	14 MONTHS
DUE TO, OR AS A CONSEQUENCE OF (c)	METASTATIC PROSTATE CANCER	14 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐					

22a. I certify that ☒ (this hospital) attended the deceased from FEBRUARY 1, 1989, to FEBRUARY 9, 1989, that ☒ (we) last saw the deceased alive on FEBRUARY 9, 19 89, and that in ☒☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (☒☒) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Noa Ben-Baruch M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	02-09-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
NOA BEN-BARUCH M.D.	NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MD 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb. 13 1989	Ferncliff Cemetery	Hartsdale,	New York	

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814	FEB 13 '89	Julia Davidson-Randall

BP 15

DHMH 16-60M 7/84 (VRA 15. 4)

025293 MAR 1989

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05637

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Thomas	MIDDLE: Jefferson	LAST: Scott	2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☑	MONTH: 2 DAY: 12 YEAR: 1989
2b. HOUR OF DEATH	2 A M				
3. SEX	male				
4. RACE	white				
5. DATE OF BIRTH	MONTH: 6 DAY: 19 YEAR: 19				
6. AGE (IN YEARS LAST BIRTHDAY)	69 YRS.	IF UNDER 1 YR. MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:
2c. DATE PRONOUNCED DEAD	MONTH: 2 DAY: 12 YEAR: 19 89				
2d. HOUR	1025 P M				
3a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania				
7b. CITIZEN OF WHAT COUNTRY?	United States				
8.	MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐				
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery Co., MD.				
10. CITY OR TOWN OF DEATH	Bethesda				
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	5407 Waneta Road				
12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING WORKING LIFE)	Russian Translator				
12b. KIND OF BUSINESS OR INDUSTRY	U.S. Library of Congress				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES ☐ NO X	5407 Waneta Road 20816

14. FATHER'S NAME — FIRST / MIDDLE / LAST	UNKNOWN	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	UNKNOWN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	No	16b. SOCIAL SECURITY NO.	579-38-4321
17. INFORMANT — ADDRESS	Mrs. H. Vivian Swinson, Friend, 1117 South Forest Drive, Arlington, Virginia 22204		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio Respiratory arrest	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): chronic alcoholism

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO XX
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Taubor M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-13-89

EXAMINER'S NAME (TYPE OR PRINT): John Taubor ADDRESS: 8218 Wisconsin Ave Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Cremation	Feb. 14, 1989	Metropolitan Crematorium, Inc.	Bethesda, Maryland	
24. FUNERAL DIRECTOR NAME AND ADDRESS	Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814	25a. DATE REC'D. BY REGISTRAR	FEB 16 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

07/84 25M BP 1

DHMH - 17 (VR A15 ME (5))

024085 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005638 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ANNA	MIDDLE: V.	LAST: SETTERSTROM	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 9, 1989	2b. HOUR: 8:05A M	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: MARCH 18, 1895	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): SWEDEN	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: GAITHERSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS): WILSON HEALTH CARE CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES ☐ NO ☒	10319 ROYAL ROAD 20903

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
WILHELM / CHELLGREN	IDA / SAND

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		215-38-7128	DAUGHTER DORIS S. ANDERSON	SILVER SPRING, MD. 15101 INTERLACHEN DR. #112

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Brain Syndrome
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/24 19 84, to 2-9 19 89, that (I) (we) last saw the deceased alive on 1/2/89 19 ( ), and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Thos. E. Fencl MD FOR JAMES MOORE M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
THOS E. FENCL MD FOR JAMES MOORE M.D.	19291 MONTGOMERY VILLAGE GAITHERSBURG, MD 20879

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
REMOVAL	FEB. 14, 1989	MEMORIAL PARK	PARK RIVER, WALSH, NO. DAKOTA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901	FEB 13 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

024087 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005639

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen	MIDDLE: M	LAST: Seville	
2a. DATE OF DEATH MONTH: 2	DAY: 9	YEAR: 89	2b. HOUR: 3:10 A.M.
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: 7 DAY: 02 YEAR: 19	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: TAKOMA PARK	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
			13e. STREET ADDRESS / ZIP CODE: 805 MAPLEWOOD AVENUE 20912
14. FATHER'S NAME FIRST: JAMES	MIDDLE: J.	LAST: BRADLEY	15. MOTHER'S MAIDEN NAME FIRST: CATHERINE MIDDLE:	LAST: GLENNEN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: 176-05-4031	17. INFORMANT ADDRESS: JOHN B. SEVILLE/SON/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE 1a) Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Brain stem infarct — Days

DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral vascular disease - CVA — days → 40s

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 2, 19 89, to Feb 9, 19 89, that (I) (we) last saw the deceased alive on Feb 8, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert H. Goldman — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT H. GOLDMAN — 22e. ADDRESS: 1106 SPRING ST. SILVER SPRING MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 10, 1989	23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: ROCKVILLE MONTGOMERY MARYLAND
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D BY REGISTRAR: FEB 13 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

BP 40

DHMH - 16 60M 7/84
(VRA 15, 4)

22603 FEB 13 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05640 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Charles E. Seymour	2a. DATE OF DEATH MONTH / DAY / YEAR	2 / 2 / 89	2b. HOUR	8 45 PM
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH / DAY / YEAR	7 / 31 / 95
6. AGE (IN YEARS LAST BIRTHDAY)	93 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery MD.				
10. CITY OR TOWN OF DEATH	Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Wilson Health Care Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Minister
12b. KIND OF BUSINESS OR INDUSTRY	Methodist				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Montgomery	13c. CITY OR TOWN	Gaithersburg
13d. INSIDE CITY LIMITS? YES [X] NO [ ]		13e. STREET ADDRESS / ZIP CODE	407 Russell Avenue APt. 209 / 20877		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Unknown	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	------	16b. SOCIAL SECURITY NO.	218-22-6798
17. INFORMANT	Mildred B. Seymour	ADDRESS	Gaithersburg, MD 20877		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ASPIRATION Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cerebrovascular disease — Years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~the hospital~~) attended the deceased from August, 19 89, to February 2, 19 89, that (~~I~~) (we) last saw the deceased alive on February 2, 19 89, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	Byrl D. Johnson	DEGREE	MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED	2/3/89		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	BYRL D. JOHNSON	22e. ADDRESS	911 N. Russell Ave. Gaithersburg, md. 20878

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	02-04-89	23c. NAME OF CEMETERY OR CREMATORY: Wards Chapel Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Marriotsville Baltimore MD			
24. FUNERAL DIRECTOR NAME / ADDRESS	Haight Funeral Home Sykesville, MD 21784	25a. DATE REC'D. BY REGISTRAR	FEB 08 1989	25b. REGISTRAR'S SIGNATURE: Julia Dixon-Landers

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

024074 FEB 29 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR — REG. NO. 89 055411

1. DECEASED NAME (TYPE OR PRINT): FIRST Mary MIDDLE Lou LAST Shafferman (Mary Shafferman)
2a. DATE OF DEATH: MONTH 2 DAY 10 YEAR 89
2b. HOUR: 8:15 P.M.
3. SEX: Female
4. RACE: White W
5. DATE OF BIRTH: MONTH 04 DAY 17 YEAR 14
6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Sec'ty.
12b. KIND OF BUSINESS OR INDUSTRY: N.I.H.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD.
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 10500 Rockville Pike # 1309 20852

14. FATHER'S NAME: FIRST Raymond MIDDLE LAST Hawkins
15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE A. LAST Deck
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 577-40-5356
17. INFORMANT: Linda S. Edgeman Same as item # 13 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DF ATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Malnutition
DUE TO, OR AS A CONSEQUENCE OF (c) Polycythemia Vera
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days / months / years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-30-89 19__ to 2-11 19 89, that (I) (we) last saw the deceased alive on 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the couses stoted above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Daniel A. Fuller
22e. ADDRESS: 19511 Doctors Dr, Germantown, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/14/89
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION CITY OR TOWN: Silver Spring COUNTY: MD STATE

24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 WI Ave. NW Wash., DC 20016
25a. DATE REC'D. BY REGISTRAR: FEB 15'89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH-16 50M 1/81 (VRA 15, 4)

023469 FEB 22 89

1. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05642
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALEX MIDDLE: LAST: SHAUB				2a. DATE OF DEATH MONTH DAY YEAR: 02/16/89	2b. HOUR: 3A.M.
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 2, 1892	6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Russia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Manufacturer	12b. KIND OF BUSINESS OR INDUSTRY: Ladies Garments		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 6121 Montrose Road 20852	
14. FATHER'S NAME FIRST MIDDLE LAST: Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 092-01-1485	17. INFORMANT: Leonard Shaub	ADDRESS: 310 East 46th Street New York, N.Y. 10017	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 HOURS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): ASPIRATION PNEUMONITIS
DUE TO, OR AS A CONSEQUENCE OF (c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): —

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/26/84 to 2/16/89 that (I) (we) last saw the deceased alive on 2/16/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M.D.	DEGREE: M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/16/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. D. PATEL	22e. ADDRESS: 6121 MONTROSE RD ROCKVILLE MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/19/89	23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Gdns.	23d. LOCATION CITY OR TOWN: Falls Church, Va.	COUNTY / STATE
24. FUNERAL DIRECTOR NAME: Ives-Pearson Funeral Home ADDRESS: 472 N. Washington St., Falls Church, Va.		25a. DATE REC'D. BY REGISTRAR: FEB 21 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 BP

DHMH - 16 60M 7/84
(VRA 15, 4)

025-280 MAR 1-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 056433 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Mazbelle F. Shearer				2a. DATE KNOWN OF DEATH ESTIMATED (MONTH DAY YEAR)	Feb. 15 19 89
2b. HOUR	10:03					
3. SEX	F	4. RACE	W	5. DATE OF BIRTH (MONTH DAY YEAR)	Dec 24 97	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.
IF UNDER 1 YR. MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.		2c. DATE PRONOUNCED DEAD (MONTH DAY YEAR)	Feb 15 19 89	2d. HOUR 10:03 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	OHIO	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH	S. I. Spg	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Holy Cross Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	SCHOOL TEACHER	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND	13b. COUNTY	MONTGOMERY	13c. CITY OR TOWN	SILVER SPRING	13d. INSIDE CITY LIMITS? YES X NO ☐
13e. STREET ADDRESS	10000 BRUNSWICK AVENUE 20910					
14. FATHER'S NAME FIRST / MIDDLE / LAST	CLYDE L. FERRALL			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	JULIA ASHBROOK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	183-32-4149	
17. INFORMANT	NIECE	ADDRESS	5012 HAMPDEN LN	JEAN B. MILLER	BETHESDA, MD 20814	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardial Dis 1 Yr.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
None		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Dep MEDICAL EXAMINER DATE SIGNED 2/15/89

EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.D. ADDRESS 1919 SEMINARY RD SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 18, 1989	ALLEGHENY MEM PARK	ALLISON PARK ALLEGHENY PA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 17 '89	Julia Davidson-Randall

024955 MAR - 8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056444 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. If the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	ROLAND Albus SHERWOOD	2a. DATE OF DEATH MONTH DAY YEAR	FEBRUARY 18, 1989	2b. HOUR	1:42 pM
3. SEX	MALE	4. RACE	Caucasian	5. DATE OF BIRTH MONTH DAY YEAR	06 14 10
6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	New York City, N.Y.	7b. CITIZEN OF WHAT COUNTRY?	US	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH	OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MONTGOMERY GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired Wholesaler
12b. KIND OF BUSINESS OR INDUSTRY	Arnold Bread Co.				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Laurel	YES XX NO ☐	8806 Barnsley Court # 21 20708

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Harry J. Sherwood	Theresa (unkown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
n/a	n/a	072-09-3585	Douglas R. Sherwood 5800 Griffith Rd. Laytonsville Maryland 20879

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Resp-Cabac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis

DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐ ☑	19	Auto accident

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Street	

22a. I certify that (I) (this hospital) attended the deceased from 2/18, 19 89, to 2/18, 19 89, that (I) (we) last saw the deceased alive on 2/18 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner

22e. ADDRESS 4301 Randolph Rd Rockville Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/22/89	Baltimore Washington Crematory	Laurel P.G. Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25c. DATE REC'D. BY REGISTRAR	25d. REGISTRAR'S SIGNATURE
Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Md. 20707	FEB 28 '89	Julia Davidson-Kendall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

24137 FEB 29 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005645

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ARTHUR MIDDLE: H. LAST: SHOGREN			2a. DATE OF DEATH MONTH DAY YEAR: 2/2/89	2b. HOUR: 05.58 A.M.
3. SEX: Male	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 07/07/19	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.	# UNDER 1 YEAR: MONTHS / DAYS; # UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: GAITHERSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ELECTRICIAN	12b. KIND OF BUSINESS OR INDUSTRY: CONTRACTING
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: DAMASCUS	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 9813 BETHESDA CHURCH RD
14. FATHER'S NAME FIRST: ERNEST MIDDLE: LAST: SHOGREN			15. MOTHER'S MAIDEN NAME FIRST: FLORENCE MIDDLE: M. LAST: JONES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 034-05-7943	17. INFORMANT: HARRY A. SHOGREN (SON)	ADDRESS: 14 ENCK DRIVE BOILING SPRINGS, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): EPIDERMOID CARCINOMA OF LEFT LUNG — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SEVERE GENERALIZED ARTERIOSCLEROSIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from JANUARY 18, 19 89, to FEBRUARY 2, 19 89, that (I) (~~we~~) last saw the deceased alive on FEBRUARY 1, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: James A. Brown — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES A BROWN, MD

22e. ADDRESS: 14808 PHYSICIANS LANE ROCKVILLE, MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: FEB. 3, 1989	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY	23d. LOCATION CITY OR TOWN: SUITLAND COUNTY: P.G. CO. STATE: MARYLAND
24. FUNERAL DIRECTOR NAME: WILHELM FUNERAL HOME ADDRESS: SUITLAND, MARYLAND	25a. DATE REC'D BY REGISTRAR: FEB 09 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

025370 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 : 05646 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)	FIRST: CARROLL MIDDLE: LAST: SIMMS
2a. DATE OF DEATH	MONTH 2 DAY 18 YEAR 89
2b. HOUR	12:20 AM
3. SEX	MALE
4. RACE	Black
5. DATE OF BIRTH	MONTH 10 DAY 5 YEAR 03
6. AGE (IN YEARS LAST BIRTHDAY)	85 YRS
IF UNDER 1 YEAR	MONTHS / DAYS
IF UNDER 24 HRS	HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md.
7b. CITIZEN OF WHAT COUNTRY?	USA
8.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery County MD.
10. CITY OR TOWN OF DEATH	Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Medlantic Manor@Layh III
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Trash Collator
12b. KIND OF BUSINESS OR INDUSTRY	TRASH
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Montgomery Co.
13c. CITY OR TOWN	Rockville
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐
13e. STREET ADDRESS	701 Burgundy Rd. Rockville Md.
14. FATHER'S NAME	FIRST Orther MIDDLE LAST Simms
15. MOTHER'S MAIDEN NAME	FIRST SARAH MIDDLE LAST Sewell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	219-07-9077
17. INFORMANT	Thelma Washington
ADDRESS	6233 Addison Rd. Seat Pleasant MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma metastatic prostate

DUE TO, OR AS A CONSEQUENCE OF (c) esophagitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Year / month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

diabetes mellitus

19a. DATE OF OPERATION	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?	YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED	WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-9-89 19 to 2-18 19 89, that (I) (we) last saw the deceased alive on 2-18-89 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	C Feinstein MD
DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐
22c. DATE SIGNED	2.18.89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	C. FEINSTEIN MD
22e. ADDRESS	18111 PRINCE PHILIP Dr. Olney Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2-23-89	Parklawn Mem. Park	Rockville,	Montg. MD

24. FUNERAL DIRECTOR NAME / ADDRESS	George R. Snowden Rockville, MD 20850	25a. DATE REC'D BY REGISTRAR	FEB 21 '89
25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05647
REG. NO.

0243 03 FEB 29 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Samuel — MIDDLE: — LAST: Simon
2a. DATE OF DEATH — MONTH DAY YEAR: 2-23-89
2b. HOUR: 1:07 AM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: 7-14-05
6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD
10. CITY OR TOWN OF DEATH: Silver Spring, MD
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ELCTRICIAN
12b. KIND OF BUSINESS/INDUSTRY: GOVERNME PRINTING OFF.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: SILVER SPRING
13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS: 9039 SLIGO CREEK PARKWAY 20901

14. FATHER'S NAME — FIRST: JACOB — MIDDLE: — LAST: SIMON
15. MOTHER'S MAIDEN NAME — FIRST: GOLDIE — MIDDLE: — LAST: GLASS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 577-38-7328
17. INFORMANT — ADDRESS: PAULINE R. SIMON, 9039 SLIGO CREEK PKWAY. SILVER SPRING, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO XX
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/10/89 to 2/23/89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. (I) (we) last saw the deceased alive on 2/23/89
22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/23/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Isa Cankardo
22e. ADDRESS: 10301 Georgia Ave Sly MD

23a. BURIAL, CREMATION, REMOVAL: BURIAL
23b. DATE: 2/26/1989
23c. NAME OF CEMETERY OR CREMATORY: DISTRICT OF COLUMBIA LODGE CEMETERY
23d. LOCATION — CITY OR TOWN: WASHINGTON — COUNTY: — STATE: D. C.
24. FUNERAL DIRECTOR (NAME AND ADDRESS): DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.
25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

025278 MAR 1 '89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05648
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 20

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: L.	LAST: SITES	2a. DATE OF DEATH MONTH DAY YEAR: FEB 15 1989	2b. HOUR: 6:45 P M
3. SEX: Female	4. RACE: CAUCASION	5. DATE OF BIRTH MONTH DAY YEAR: 3 9 33	6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	ROCKVILLE	YES [X] NO [ ]	4520 BESTOR DRIVE 20853

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WILFRED	J.	MATHEWSON	HELEN		McMILLIAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		578-42-7510	ELROY R. SITES/HUSBAND/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis	24 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	leukopenia	48 hours
DUE TO, OR AS A CONSEQUENCE OF (c)	chemotherapy for hemangiopericytoma	5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): metastatic cancer (hemangiopericytoma)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from Jan, 19 88, to present, 19 ____, that (I) (we) last saw the deceased alive on Feb 15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
John Barr, MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Barr, MD	10810 Connecticut Ave, Kensington Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 21, 1989	GATE OF HEAVEN CEM.	SILVER SPRING MONTGOMERY MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 17'89	Julia Davidson-Randall

025366 MAR 16 89

1a FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005649 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Effie MIDDLE: Davis LAST: Smith			2a. DATE OF DEATH MONTH: 02 DAY: 19 YEAR: 89	2b. HOUR: 335 P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 6 DAY: 27 YEAR: 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Caroline	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Doctor's Hospital	12b. KIND OF BUSINESS OR INDUSTRY: Nurses Aid		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Mont	Rockville	YES ☒ NO ☐	199 Rollins Avenue 20852

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT
Theodore Davis	Minnie A Clements	N/A (IF YES, GIVE WAR OR DATES)	577 42 9695	Jerry Smith (Son) ADDRESS: 1489 Autumn Rd. Spring Hill, Florida

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardio respiratory arrest	1 hr.
DUE TO, OR AS A CONSEQUENCE OF (b)	arteriosclerosis	15 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): mucosa septi amia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov 19 70 to Feb 19 89, that (I) (we) last saw the deceased alive on Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John M Wynne	7901 Norfolk Ave Bethesda MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/22/89	Ft. Lincoln	Brentwood	PG	Md.

24. FUNERAL DIRECTOR (SIGNATURE)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines-Rinaldi 11800 New Hampshire Ave. S.S.Md.	FEB 21 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

Records 10

DHMH - 16 50M 1/81 (VRA 15, 4)

025353 MAR 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 05650

REG. NO

1. DECEASED NAME (TYPE OR PRINT): FIRST FLORINE MIDDLE J. LAST SMITH

2a. DATE OF DEATH: MONTH 2 DAY 17 YEAR 89

2b. HOUR 5:18 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 12 DAY 14 YEAR 01

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NORTH CAROLINA

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Montgomery

13c. CITY OR TOWN: CHEVY CHASE

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 4730 BRADLEY BLVD 20815

14. FATHER'S NAME: FIRST JAMES MIDDLE W. LAST JENNINGS

15. MOTHER'S MAIDEN NAME: FIRST SALLIE MIDDLE B. LAST BLAIR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 246-05-8735

17. INFORMANT: SON ADDRESS: 1241 REDWOOD CT. ROY L. SMITH, JR. MARCO ISLAND, FL 33937

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	SEPTICEMIA	4 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)	CELLULITIS ABDOMINAL WALL	4 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	SENILE INANITION + DEMENTIA	YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/2 1988 to 2/17 1989, that I (we) last saw the deceased alive on 2/17 1989, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Martin Shargel DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTIN C. SHARGEL

22e. ADDRESS: 3720 FARRAGUT AVE. KENSINGTON, MD 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: FEB 22, 1989

23c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY

23d. LOCATION CITY OR TOWN WASHINGTON, DC COUNTY STATE

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25a. DATE REC'D. BY REGISTRAR: FEB 22 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

U24081 FEB 28 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005651
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: WILLIAM MIDDLE: F. LAST: SMITH		2a. DATE OF DEATH MONTH DAY YEAR: 2-6-89	2b. HOUR: 11 54 PM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 10 - 1 1897	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Attorney/Accountant	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Chevy Chase	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 4720 Chevy Chase Dr. (20815)			
14. FATHER'S NAME FIRST: William MIDDLE: F. LAST: Smith		15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: Ann LAST: Connoly	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 217 44 0533	17. INFORMANT: Wife	ADDRESS: Same as # 13 above.
		Margot E. Smith	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ascending cholangeitis
DUE TO, OR AS A CONSEQUENCE OF (b): Common Bile duct Blockage
DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma of Bile duct presumed
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1975 19__ to 2/6/89 19__, that (I) (we) last saw the deceased alive on 2/6/89 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jeremy V Cooke	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/7/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jeremy V. Cooke	22e. ADDRESS: 10400 Conn. Ave, Kensington		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: Feb. 10, 1989	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Alexandria VA.
24. FUNERAL DIRECTOR NAME: Robert A. DeVol	ADDRESS: DeVol Funeral Home 2222 Wisc. Ave Washington D.C.	25a. DATE REC'D BY REGISTRAR: FEB 09'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 89

1- FOR STATE REGISTRAR

REG. NO. 05652

0253044 MAR 14 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Mary — MIDDLE: — LAST: Snurr
2a. DATE OF DEATH — KNOWN ☒ ESTIMATED ☐ — MONTH: Feb — DAY: 12 — YEAR: 89
2b. HOUR: 1:24 ☒ A.M. ☐ P.M.
3. SEX: F
4. RACE: W
5. DATE OF BIRTH — MONTH: Jan — DAY: 15 — YEAR:
6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.
IF UNDER 1 YR. — MONTHS: — DAYS:
IF UNDER 24 HRS. — HOURS: — MIN.:
2c. DATE PRONOUNCED DEAD — MONTH: Feb — DAY: 12 — YEAR: 1989
2d. HOUR: 1:24 ☒ A.M. ☐ P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spg.
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10009 Markham St
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: Mont
13c. CITY OR TOWN: Silv Spg
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 10009 Markham St 2090

14. FATHER'S NAME — FIRST: GEORGE — MIDDLE: DEXTER — LAST: KEHOE
15. MOTHER'S MAIDEN NAME — FIRST: MARY — MIDDLE: AGNES — LAST: VOLKMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 578-07-9190
17. INFORMANT: ATTORNEY JOHN CARMODY — ADDRESS: 1010 WAYNE AVE SILVER SPRING, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Dis.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).: None

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:
20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: John S. Rogers, M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Feb 12 1989

EXAMINER'S NAME (TYPE OR PRINT): JOHN S. ROGERS, M.D. ADDRESS: 1919 SEMINARY ROAD SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: FEB 15, 1989
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.
23d. LOCATION CITY OR TOWN: SILVER SPRING COUNTY: MONTGOMERY STATE: MD

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901
25a. DATE REC'D. BY REGISTRAR: FEB 15 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 20

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05653
REG. NO.

02474 MAR - 8

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Nellie — MIDDLE: Lewis — LAST: Snyder

2a. DATE OF DEATH — MONTH: 2 — DAY: 18 — YEAR: 89

2b. HOUR: 5:30 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: 8 — DAY: 20 — YEAR: 91

6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Asbury Methodist Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Mont.

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 301 Russell Avenue 20877

14. FATHER'S NAME — FIRST: John — MIDDLE: — LAST: Lewis

15. MOTHER'S MAIDEN NAME — FIRST: Kate — MIDDLE: C. — LAST: Lewis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. SOCIAL SECURITY NO.: 213-34-1954

17. INFORMANT: J. Edward Snyder — ADDRESS: 1224 Perry Williams Dr McLean, VA 22101

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Intestinal Obstruction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2½ mo

DUE TO, OR AS A CONSEQUENCE OF (b): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Osteoarthritis, Osteoporosis

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) this hospital) attended the deceased from Feb 1, 19 82, to Feb 18, 19 89, that (I) we) last saw the deceased alive on Feb 16, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-18-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James R. Moore Jr.

22e. ADDRESS: 207 Brookes Ave Gaithersburg Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb 21, 1989

23c. NAME OF CEMETERY OR CREMATORY: Greenmount

23d. LOCATION — CITY OR TOWN: Baltimore City — COUNTY — STATE: MD

24. FUNERAL DIRECTOR — NAME: Taylor Funeral Chapel — ADDRESS: Annapolis, MD

25a. DATE REC'D. BY REGISTRAR: FEB 21 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 1

DHMH - 16 60M 7/84
(VRA 15, 4)

023139 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05654

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR 2b. HOUR
Sylvia	O.	Snyder	2-11		19 89 M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	March 12, 1912	76 YRS.		
2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
	2-11		19 89	7:25 a. M	

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, D.C.	U.S.A.		Montgomery County, MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban Hospital	Homemaker	Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS
Maryland	Montgomery	Rockville		10500 Rockville Pike,#1227 (20852)

14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Joseph	Oxenburg	Emma	Baefsky
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	--------	578-01-0052	Charlotte Zuckman;Daughter;1235 Derbyshire Road; Rockville, Md.20854

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple Injuries	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	6:00 XX 2-11 19 89	subject jumped from 12th floor of building
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	Home	10500 Rockville Pike,#1227,Rockville, Montgomery Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Chief MEDICAL EXAMINER DATE SIGNED 2-12-89

EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn St., Balto., Md. 21202

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2/13/89	Beth Sholom Cong. Cemetery	Capitol Heights, Md.	
24. FUNERAL DIRECTOR NAME	DANZANSKY-GOLDBERG MEMORIAL CHAPELS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
1170 Rockville Pike; Rockville, Md . 20852		FEB 15 1989	[signature]	

07/84 25M BP____

DHMH - 17 (VR A15 ME (5))

0232 4 S FEB 21 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05655
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Earl MIDDLE: LAST: Sodeman

2a. DATE OF DEATH MONTH DAY YEAR: Feb 14, 1989

2b. HOUR: 3:30 PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Feb. 9, 1919

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: S.S.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired-Painting Estimator

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Mont

13c. CITY OR TOWN: S.S.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 14724 Claude Lane 20904

14. FATHER'S NAME FIRST MIDDLE LAST: Andrew Sodeman

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Ethel James

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 212 12 0433

17. INFORMANT ADDRESS: Evelyn Sodeman (Wife) Same as 13E

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Massive GI bleeding — hours.

DUE TO, OR AS A CONSEQUENCE OF (c): Cardiac failure — hours.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 2/14 19 89, to 2/14 19 89, that (I) (we) last saw the deceased alive on 2/14/89 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ELBA J. MARTINEZ, M.D.

22e. ADDRESS: 8008 Hodder Hill LA - Potomac, MD 208

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/18/89

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION CITY OR TOWN COUNTY STATE: Brentwood PG Md.

24. FUNERAL DIRECTOR NAME ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md

25a. DATE REC'D. BY REGISTRAR: FEB 16 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

D25289 MAR 14 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05656
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 38 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Arthur MIDDLE: Theodore LAST: Sonnenberg				2a. DATE OF DEATH MONTH DAY YEAR: 2-16-89	2b. HOUR: 12:30 A.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 30, 1920	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Transport. Economist	12b. KIND OF BUSINESS OR INDUSTRY: Fed. Hwy. Admin.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 5808 Johnson Avenue / 20817	
14. FATHER'S NAME FIRST: Arthur MIDDLE: LAST: Sonnenberg			15. MOTHER'S MAIDEN NAME FIRST: Augusta MIDDLE: LAST: Marquard		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	IF YES, GIVE WAR OR DATES: WW II	16b. SOCIAL SECURITY NO.: 164-12-8849	17. INFORMANT: Mary F. Waldrop,	ADDRESS: Same as 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Thrombophlebitis Deep Vein Thrombosis (R) — 5 days

DUE TO, OR AS A CONSEQUENCE OF (c): Small Cell Cancer of Lung — 6 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Epidural Metastasis - Spinal Cord compression

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Nov 12 19 88, to 16 Feb 19 89, that (I) (we) last saw the deceased alive on 16 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Eugene P. Libré	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 16 Feb 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Eugene P. Libré MD	22e. ADDRESS: 10460 Connecticut Ave Kensington, MD. 20895		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2-16-89	23c. NAME OF CEMETERY OR CREMATORY: Suburban Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, Maryland
24. FUNERAL DIRECTOR NAME: Rapp Funeral Services, P. A. ADDRESS: 933 Gist Avenue, Silver Spring, MD 20910		25a. DATE REC'D. BY REGISTRAR: FEB 16 '89	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

023364 FEB 2 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05657
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARIA MIDDLE: LAST: SSANGULIA				2a. DATE OF DEATH MONTH DAY YEAR: 01-30-89	2b. HOUR: 2 34 PM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 4-28-09	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS HOURS MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Germany	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Air Express Comp		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: P.G.Co.	13c. CITY OR TOWN: Riverdale	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 6110 44th Pl 20737	
14. FATHER'S NAME FIRST: OTTO MIDDLE: LAST: SIMSCH			15. MOTHER'S MAIDEN NAME FIRST: EMMA MIDDLE: LAST: TSCHAECHE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): --------	16b. SOCIAL SECURITY NO.: 215-32-0782A	17. INFORMANT: WALERIAN SSANGULIA	ADDRESS: (SAME AS ITEM #13)		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Fulminant Sepsis

DUE TO, OR AS A CONSEQUENCE OF (c): Pneumonia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-26-89 19 89 to 1-31 19 89, that (I) (we) last saw the deceased alive on 1-30 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 1-31-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Ronald C. Wheeler — 22e. ADDRESS: 6104018 Branch Ave Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 2-2-1989	23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREMATORY	23d. LOCATION CITY OR TOWN: RIVERDALE, COUNTY: P.G.C. STATE: Md.	
24. FUNERAL DIRECTOR NAME: W. W. CHAMBERS CO.	ADDRESS: RIVERDALE, Md. 20737	25a. DATE REC'D BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

024019 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05658
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR
HARRY	Randolph	STANFIELD, Sr.	2/17/89

2b. HOUR: 650 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
~~X~~ Male	xxx White	1 23 23	65 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
~~XXXXXX~~ W. Va.	USA		MONTGOMERY County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Montgomery	HOLY CROSS HOSPITAL	Retired	Maintenance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	MONTGOMERY	WHEATON	YES ☐ NO ☒	12118 CENTERHILL ST 20902

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Calvin		Stanfield	Ocie		Sparks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	234-24-6777	JeanPierre Stanfield	3023 Henrwood Rd., Woodstock, Md. 21163

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebropulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Epigastric with metastasis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
(1) Aspiration pneumonia (2) Peritonitis (3) Hypoxemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/4/89 to 2/17/89, that (I) (we) last saw the deceased alive on ____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
A A Chacko	MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A. A CHACKO	7610 Carroll Ave # 390 Takoma Pk MD 20912

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	2/19/89	Security Process Inc.	Catonsville, Balto., Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
McCully Funeral Homes	237 E. Patapsco Ave. Baltimore, Md. 21225	FEB 22 1989	Carole Ann Randall

BP 10/11

DHMH - 1650M 1/81 (VRA 15, 4)

022976 FEB

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005659 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL (SEE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER (LOCAL UNIT) FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR	
Leonard	Alan	Steinbach	2-5-89		19		M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
MALE	CAUCASIAN	4-29-42	46 YRS.			2-5- 19 89	8:10 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X	9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.		Montgomery County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring	Wheaton Plaza N. Office Bldg. (512 Suite)	CONSULTANT-ADVISOR	BUSINESS				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS			
MARYLAND	MONTGOMERY	ROCKVILLE		14416 PARKVELE RD. 20853			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST		
RALPH		STEINBACH	BETTYE		OSEROFF		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
NO		219-38-3852	RALPH STEINBACH	6210 PARK HTS. AVE, APT 902 BALTO., MD 21215			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Contact gunshot wound of head
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 2-6-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) office	21f. LOCATION STREET Wheaton Plaza, N. Office Bldg., CITY OR TOWN Suite 512, Silver Spring, COUNTY Montgomery County, STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural Causes ☐ Accident ☐ Suicide XX Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-6-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/8/89	AITZ CHAIM CEMETERY	BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		FEB 10 1989	Julia Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025380 MAR 16 89

1a FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05660 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Marguerite	Middle: P.	Last: Stevenson	2a. DATE OF DEATH Month Day Year: February 18, 1989	2b. HOUR: 6:00 pm	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH Month Day Year: July 11, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Oklahoma	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County,		MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 5600 Roosevelt Street/20817	
14. FATHER'S NAME First: Benjamin	Middle:	Last: Perry	15. MOTHER'S MAIDEN NAME First: Grace	Middle:	Last: Smart
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 441 26 0822	17. INFORMANT (Husband)	ADDRESS: James O. Stevenson	Same as line #13.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b): Emphysema — 10 years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/20 19 24, to 2/18 19 89, that (I) (we) last saw the deceased alive on 2/18 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE AND DEGREE: J. D. Herman M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John D. Herman — 22e. ADDRESS: 4425 Montgomery Ave. Bethesda, Md 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: February 20 1989	23c. NAME OF CEMETERY OR CREMATORY: Montgomery Crematorium, Inc.	23d. LOCATION CITY OR TOWN: Bethesda	COUNTY:	STATE: Maryland
24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Homes/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 35

DHMH-16 50M 1/81 (VRA 15, 4)

02337 I_FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05661
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: MARLEE CHRISTINE STEWART				2a. DATE OF DEATH MONTH DAY YEAR: JANUARY 28, 1989	2b. HOUR: 12:11 A M
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 27, 1989	6. AGE (IN YEARS LAST BIRTHDAY) — YRS.	IF UNDER 1 YEAR: MONTHS 0 DAYS 0	IF UNDER 24 HRS: HOURS 1 MIN. 42
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY, MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None	12b. KIND OF BUSINESS OR INDUSTRY: None		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: DELAWARE	13b. COUNTY: SUSSEX	13c. CITY OR TOWN: OCEANVIEW	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: R.D.#1 Box 22A/19970	
14. FATHER'S NAME FIRST MIDDLE LAST: LEE HOWARD STEWART			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: MARYLYNN MILLSAP		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: -	17. INFORMANT ADDRESS: Lee H. Stewart Same as line #13.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANENCEPHALY
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (☒ this hospital) attended the deceased from JANUARY 27, 19 89, to JANUARY 28, 19 89, that (☒ we) last saw the deceased alive on January 28, 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (☒ we) (did) (did not) view the body after death.

22b. SIGNATURE: William C. Wassel	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED 1989 JANUARY 29
22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM CHARLES WASSEL, LT, MC, USNR	22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 01, 1989	23c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE: South Whitehall/Lehigh/Pa.	
24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Homes/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR: JAN 31 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

023359 FEB 2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05662
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert MIDDLE: LAST: Stewart				2a. DATE OF DEATH MONTH: 1 DAY: 30 YEAR: 89	2b. HOUR: 8A M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH: 1 DAY: 27 YEAR: 13	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS HOURS: MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): plumber	12b. KIND OF BUSINESS OR INDUSTRY:		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
md	Mont.	Kensington	YES [X] NO [ ]	4107 Myers Mill Rd 20895

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: Marshall MIDDLE: Stewart LAST:	FIRST: Eliza MIDDLE: Turner LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
NO	579-16-7696	Nellie Stewart (wife)	same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	3 d
DUE TO, OR AS A CONSEQUENCE OF (b)	Pneumonia	3 d
DUE TO, OR AS A CONSEQUENCE OF (c)	Lung cancer	1 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bone metastases Node metastases

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/88	Lymph Node Bx	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 2 , 19 89 , to 1/30 , 19 89 , that (I) (we) last saw the deceased alive on 1/29 , 19 89 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Peter Sherer	MD	ATTENDING PHYSICIAN [X]	MEDICAL DIRECTOR [ ]	STAFF PHYSICIAN [ ]	1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Peter Sherer MD	3947 Ferrara Dr. Wheaton, md 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-4-89	Ash Memorial Cem.	Sandy Spring, Montg. MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George R. Snowden Rockville, MD 20850	FEB 03 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

024075 FEB 2 0 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05663
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Katharine	Celeste	Stokes	Feb. 7 1989	3:30A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	August 26,1895	93 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	XX	Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Fernwood Nursing Center	Editor	Dept of Commerc

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
None	None	Wash. D.C.	YES X NO	4201 Mass Ave.,N.W. / 20016

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	H. O.	Stokes	Katherine	-	Friel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	578 58 3863	Sister Elizabeth F. Stokes	Same as # 13 above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pnuemonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Circulating Anticoagulant against Factor VIII

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES NO XX	YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1982, 19__, to Feb.7, 19 89, that (I) (we) last saw the deceased alive on Feb.2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
R.W. Langevin	MD	X	Feb.7,1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R.W. Langevin M.D.	1234 19th St. N.W./Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	Feb.10,1989	Chester Cemetery	Chestertown Kent Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DeVol Funeral Home Robert A. DeVol	2222 Wisc. Ave. Washington D.C.	FEB 09'89	Julia Davidson-Randell

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 20

DHMH - 16 60M 7/84
(VRA 15, 4)

025347 MAR 16 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05664 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 16 50M 1/89 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Violetta	MIDDLE: L.	LAST: Stone	2a. DATE OF DEATH MONTH DAY YEAR: Feb. 15, 1989		2b. HOUR: 11:30P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 23, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Indiana	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Heritage Health Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Medical Asst.	12b. KIND OF BUSINESS OR INDUSTRY: Health Care		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Takoma Park	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 7525 Carroll Avenue/20912	
14. FATHER'S NAME FIRST: Edward	MIDDLE	LAST: Meyer	15. MOTHER'S MAIDEN NAME FIRST: Fannie	MIDDLE	LAST: Stainmetz
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ---	16b. SOCIAL SECURITY NO.: 579-66-0536	17. INFORMANT: John Wood	ADDRESS: 1050 Chesapeake Court, Waldorf, MD 20602	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the pancreas — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 89, to 15 Feb 19 89, that (I) (we) last saw the deceased alive on 2/14 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 17 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael E. Leibowitz	22e. ADDRESS: 11120 NH Ave, Silver Spring, MD20904

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/18/89	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Pk.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Rockville, MD
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisconsin Ave, NW, Washington, D.C. 20016	25a. DATE REC'D. BY REGISTRAR: FEB 22 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

025332 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

056655

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funerol director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harry	MIDDLE: E	LAST: Stoneman	2a. DATE OF DEATH MONTH: 02	DAY: 21	YEAR: 89
2b. HOUR: 1642 P M					
3. SEX: M	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 16, 1929	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Connecticut	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD		
10. CITY OR TOWN OF DEATH: Takoma PK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Self-Employed	12b. KIND OF BUSINESS OF INDUSTRY: Own		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: P.G.	13c. CITY OR TOWN: Riverdale	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 5403 55TH., Pl. 20737	
14. FATHER'S NAME FIRST: Harry	MIDDLE: -	LAST: Stoneman	15. MOTHER'S MAIDEN NAME FIRST: Florence	MIDDLE: L.	LAST: Bouteiller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): 1956-1961	16b. SOCIAL SECURITY NO.: 173-26-7941	17. INFORMANT: Charles Lowery	ADDRESS: 6508 Sweetwater Dr. Rockville MD. 20855		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	32 minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Myocardial infarction	
DUE TO, OR AS A CONSEQUENCE OF (c)	CardioGenic Shock	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Liver failure, Renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from FEB 21 19 89 to FEB 21 19 89, that (I) (we) last saw the deceased alive on FEB 21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] 22c. DATE SIGNED: 02/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Fayaz A. Shaw MD

22e. ADDRESS: Washington Adventist Hospital Takoma Park MD 20912

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/27/89	23c. NAME OF CEMETERY OR CREMATORY: Chambers Crematory	23d. LOCATION CITY OR TOWN: Riverdale	COUNTY: P.G. STATE: MD.
24. FUNERAL DIRECTOR NAME: W.W.Chambers Co. Inc. ADDRESS: 5801 Cleveland Ave. Riverdale Md. 20737		25a. DATE REC'D. BY REGISTRAR: FEB 24 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 8+1 gpts

DHMH - 16 50M 1/81 (VRA 15, 4)

024069 FEB 28 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR: MYRTLE L. STUP

REG. NO. 89 005666

1. DECEASED NAME (TYPE OR PRINT): First: Myrtle; Middle: L; Last: Stup

2a. DATE OF DEATH: Month 2; Day 21; Year 89

2b. HOUR: 12 15 A.M.

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH: Month 11; Day 28; Year 1907

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: GAITHERSBURG

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 407 Russell Avenue 20877

14. FATHER'S NAME: First: Laban; Middle: B.; Last: Armstrong

15. MOTHER'S MAIDEN NAME: First: Minnie; Middle: M.; Last: Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): –

16b. SOCIAL SECURITY NO.: 213-50-9955

17. INFORMANT: Dorothy L. Bready

ADDRESS: 14315 Chesterfield Rd., Rockville, Md. 20853

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio-Pulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): A.S.H.D, H.C.V.D - C.H.F. — Years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus, Idiopathic Thrombocytopenic Purpura

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from ____ 19 81 to 2-22 19 89, that (I) (we) last saw the deceased alive on 2-21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: Jack Schumacher M.D. ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-22-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jack Schumacher, M.D.

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 23, 1989

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

23d. LOCATION: CITY OR TOWN: Frederick; COUNTY: Frederick; STATE: Md.

24. FUNERAL DIRECTOR: NAME AND ADDRESS: Muriel H. Barber Funeral Home, Laytonsville, Md. 20879

25a. DATE REC'D. BY REGISTRAR: FEB 23 1989

25b. REGISTRAR'S SIGNATURE: Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

025273 MAR 14 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05667
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: FLORENCE	MIDDLE: A.	LAST: SUMMERLIN	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 16, 1989	2b. HOUR: 4:00 P M
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JULY 13, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MINNESOTA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3730 BEL PRE ROAD #4		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): INFORMATION SPECIALIST	12b. KIND OF BUSINESS OR INDUSTRY: NIH
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 3730 BEL PRE ROAD #4 20906
14. FATHER'S NAME FIRST: PETER	MIDDLE	LAST: LARSON	15. MOTHER'S MAIDEN NAME FIRST: RUTH	MIDDLE	LAST: NELSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 476-16-6115	17. INFORMANT: SON DOUGLAS F. SUMMERLIN	ADDRESS: 25-3 ZAIDEE LANE STEVENSVILLE, MD. 21666	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from [office] 19 89, to 2-1 19 89, that (I) (we) last saw the deceased alive on 2-14 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jeanne Spellman MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JEANNE R. SPELLMAN, M.D. — 22e. ADDRESS: 8830 Cameron St. Silver Spring, Md. 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 20, 1989	23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: BRENTWOOD PR. GEO. MARYLAND
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS JR. ADDRESS: 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901	25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

25306 MAR 14 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005668 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Juana	MIDDLE: M.J.	LAST: Suarez	2a. DATE OF DEATH MONTH DAY YEAR: 2 13 89	2b. HOUR: 3:45 PM
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: AUG 21 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CUBA	7b. CITIZEN OF WHAT COUNTRY?: CUBA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health CARE	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TEACHER	12b. KIND OF BUSINESS OR INDUSTRY:	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	MONTGOMERY	ROCKVILLE	YES ☒ NO ☐	415 FEATHER ROCK DRIVE 20854

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
ROGER / / SUAREZ	MARIA / / OLIVERI

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		217-94-1195	COUSIN HIPOLITO MENENDEZ	5711 WAIN WRIGHT ST ROCKVILLE, MD 20851

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 DAYS

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis — 20 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Dementia of the multi-infarct type

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
	19	

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/30/81, 19__ to 2/13/89, 19__, that (I) (we) last saw the deceased alive on 2/10/89, 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry C. Scruggs MD — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): HENRY C. SCRUGGS MD — 22e. ADDRESS: 5413 Cedar La. Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	FEB 14, 1989	METROPOLITAN CREMATORY	ALEXANDRIA VA

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25a. DATE REC'D. BY REGISTRAR: FEB 15 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 4

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005669

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Cecelia — MIDDLE: P — LAST: Sykes

2a. DATE OF DEATH — MONTH DAY YEAR: 2/7/89

2b. HOUR: 12/48 AM

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH — MONTH DAY YEAR: 3 14 51

6. AGE (IN YEARS LAST BIRTHDAY): 37 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): D.C.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery — MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Budget Analyst

12b. KIND OF BUSINESS OR INDUSTRY: Finance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: P.G.

13c. CITY OR TOWN: Cap. Hts.

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 1323 Farmingdale Ave. 20743

14. FATHER'S NAME — FIRST: Leo — MIDDLE: — LAST: Andrews

15. MOTHER'S MAIDEN NAME — FIRST: Bridie — MIDDLE: — LAST: Bruce

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 577-70-9943

17. INFORMANT — ADDRESS: Bridie Andrews-Same as # 13 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost.

DUE TO, OR AS A CONSEQUENCE OF (b): NEUTROPENIA — 30 days

DUE TO, OR AS A CONSEQUENCE OF (c): ACUTE Lymphocytic Leukemia — 3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 1986 to FEBRUARY 7 1989, that (I) (we) last saw the deceased alive on FEB 6th 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: M.D. — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Everard Hughes, M.D.

22e. ADDRESS: Holy Cross Hosp., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL

23b. DATE: 2/11/89

23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem. Pk

23d. LOCATION — CITY OR TOWN: Landover — COUNTY: — STATE: Md.

24. FUNERAL DIRECTOR — NAME: H.S. Washington & Sons — ADDRESS: 4925 Bunkers Ave.

25a. DATE REC'D. BY REGISTRAR: FEB 15 1989 — REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

022838 FEB 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05670 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	LITTLE GROVERNELL TADLOCK	2a. DATE OF DEATH MONTH DAY YEAR	FEBRUARY 10 1989
2b. HOUR	3:20 A M		
3. SEX	FEMALE	4. RACE	CAUCASIAN
5. DATE OF BIRTH MONTH DAY YEAR	NOVEMBER 25 1937	6. AGE (IN YEARS LAST BIRTHDAY)	51 YRS.
IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	ALABAMA	7b. CITIZEN OF WHAT COUNTRY?	UNITED STATES
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY MD.
10. CITY OR TOWN OF DEATH	BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	NAVAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY	NONE
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	VIRGINIA	13b. COUNTY	FAIRFAX
13c. CITY OR TOWN	SPRINGFIELD	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET ADDRESS	7104 GAME LORD DRIVE 22153		
14. FATHER'S NAME FIRST MIDDLE LAST	GROVER HENRY LITTLE	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	MARY HESTER BROGDEN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	-
16b. SOCIAL SECURITY NO.	421-48-0584	17. INFORMANT ADDRESS	JAMES D. TADLOCK, 7104 GAME LORD DRIVE, SPRINGFIELD, VA 22153

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 7, 19 89, to FEBRUARY 10, 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 10 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	C. A. Thompson	DEGREE MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED	10 Feb 89		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	C. A. THOMPSON, LT, MC, USN	22e. ADDRESS	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	BURIAL	23b. DATE	2-13-89	
23c. NAME OF CEMETERY OR CREMATORY	ABELS CEMETERY	23d. LOCATION CITY OR TOWN	GANTT	COUNTY / STATE ALABAMA
24. FUNERAL DIRECTOR NAME / ADDRESS	DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA	25a. DATE REC'D. BY REGISTRAR	FEB 14 1989	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

025000 MAR -3 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 05671

1. DECEASED NAME (TYPE OR PRINT) FIRST: LILLIAN	MIDDLE:	LAST: TASHOFF	2a. DATE OF DEATH MONTH DAY YEAR: 2-25-89	2b. HOUR: 852 PM	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: 12-3-03	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: GAITHERSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADV. NURSING	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: HOME		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	MONTG.	POTOMAC	YES ☒ NO ☐	9321 GARDEN COURT 20854

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: BENJAMIN MIDDLE: LAST: ELKIN	FIRST: ROSE MIDDLE: LAST: BECKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	N/A	059-30-9625	MR. STANLEY TASHOFF (son)	9321 GARDEN CT. POTOMAC MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory Arrest	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Organic Brain Syndrome	years
DUE TO, OR AS A CONSEQUENCE OF (c)	Cancer of Breast	years.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/30 19 88, to [illegible] 19 ____, that I (we) last saw the deceased alive on 2/16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Douglas R. Shumaker MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/26/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DOUGLAS R. SHUMAKER, MD	615 W. MONTGOMERY AVE ROCKVILLE MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-27-89	MT. HEBRON CEM..	NEW YORK

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEM CHPS INC. 1170 ROCKVILLE PK. ROCKVILLE MD 20852	MAR 03 1989	Julia Davidson-Rondeau

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 1650M 1/81 (VRA 15, 4)

023376 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 05672

1. DECEASED NAME (TYPE OR PRINT): FIRST BERNARD MIDDLE J. LAST TAYMANS

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 4 YEAR 1989 — 2b. HOUR 8:13 AM

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH 12 DAY 10 YEAR 10 — 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 4 YEAR 1989 — 2d. HOUR 8:13 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: OLNEY

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): EXECUTIVE PRINTING TRADE ASSOC.

12b. KIND OF BUSINESS OR INDUSTRY: IND. OF AMER.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: OLNEY — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 3234 Sporton Rd 20832

14. FATHER'S NAME: FIRST JOSEPH MIDDLE P. LAST TAYMANS

15. MOTHER'S MAIDEN NAME: FIRST DELIA MIDDLE LAST FOX

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 212-01-7220

17. INFORMANT / ADDRESS: HELEN S. TAYMANS WIFE SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Hour
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular Disease — 4 years
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION: N/A — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Paul A DeLore M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2/4/89

EXAMINER'S NAME (TYPE OR PRINT): Paul A DeLore MD — ADDRESS: 4203 Queensbury Rd Hyattsville MD 20781

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: FEB. 7, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN — 23d. LOCATION CITY OR TOWN: SILVER SPRING COUNTY: MONTGOMERY STATE: MD.

24. FUNERAL DIRECTOR NAME / ADDRESS: FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901

25a. DATE REC'D. BY REGISTRAR: FEB 06 '89 — 25b. REGISTRAR'S SIGNATURE: Lin Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

reorder 30

07/84 25M

BP 24+1

DHMH - 17
(VR A15 ME (5))

024134 FEB 2 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05673
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: HELEN STEPHENSON TERRY			2a. DATE OF DEATH MONTH DAY YEAR: JANUARY 30 1989	2b. HOUR: 4:45 P M
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: AUGUST 12 1920	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DISTRICT OF COLUMBIA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: POTOMAC	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS: 8514 WILKESBORO LANE 20854
14. FATHER'S NAME FIRST / MIDDLE / LAST: ELMER HORACE LORD			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: ABBIE VIRGINIA BROWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 579-07-0579	17. INFORMANT ADDRESS: ELLA S.STEPHENS, 5813 BRYN MAWR ROAD, COLLEGE PARK, MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): COLON CANCER

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 6 1989 to JANUARY 30 1989, that (I) (we) last saw the deceased alive on JANUARY 30 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C.A. Thompson MD	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 31 Jan 89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): C. A. THOMPSON, LT, MC, USNR	22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-3-1989	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Brentwood Pr. Georges Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Hines/Rinaldi Funeral Home, 11800 N.H. Ave., Silver Spring, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

25374 MAR 16 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05674 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

DHMH - 1650M 1/81 (VRA t5, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Lester Groot Thomas	2a. DATE OF DEATH — MONTH DAY YEAR	February 20, 1989	2b. HOUR: 0735 AM
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH — MONTH DAY YEAR	July 9, 1917	6. AGE (IN YEARS LAST BIRTHDAY)	71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Wash. D.D.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery MD.	
10. CITY OR TOWN OF DEATH	Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Shady Grove Adv. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	US Gov't.	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	Mont	13c. CITY OR TOWN	Mt. Airy	13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET ADDRESS	4423 Highboro Drive 21771
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Carl N. Thomas			15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Ethel VanHorn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	(IF YES, GIVE WAR OR DATES)	Navy	16b. SOCIAL SECURITY NO.	577 14 2123	17. INFORMANT — ADDRESS	Marie Thomas (Wife) Same as 13E	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST — Immed.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) PANCREATIC ADENOCARCINOMA — 3 Months

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from January 30, 19 89, to February 20, 19 89, that (I) ~~(we)~~ last saw the deceased alive on February 18, 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	George Bolen MD	DEGREE	MD, ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED	2/20/89		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	GEORGE BOLEN, MD	22e. ADDRESS	9711 MEDICAL CENTER DR, ROCKVILLE, MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	2/23/89	23c. NAME OF CEMETERY OR CREMATORY	George Washington
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Adelphi / PG / Md.				
24. FUNERAL DIRECTOR — NAME / ADDRESS	Hines/Rinaldi 11800 New Hamp. Ave. S.S, Md	25a. DATE REC'D. BY REGISTRAR	FEB 21 '89	25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall

022137 FEB 9 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05675
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Minnie	MIDDLE: Lee	LAST: Thomas	2a. DATE OF DEATH MONTH: 02	DAY: 3	YEAR: 1989	2b. HOUR: 8:50 PM
3. SEX: Female (Female)	4. RACE: Black	5. DATE OF BIRTH MONTH: 09	DAY: 05	YEAR: 09	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginai	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐			9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Private

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
		Wash.,D.C.	YES ☒ NO ☐	1379 Potomac Avenue S.E.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
STANUP / DANIELS	FLORENCE / TAYLOR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		577 09 3094-B	Husband	JOHNNIE THOMAS-1817 5th St.,N.W. Wash.,D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CHRONIC Renal failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-23 19 89 to 2-3 19 89, that (I) (~~we~~) last saw the deceased alive on 2-3 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~We~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
John Tauber	MD	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☑	STAFF PHYSICIAN ☐	2-14-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Tauber	8218 Wisconsin Ave Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/8/89	HARMONY MEMORIAL PARK	LANDOVER, P.G. MARY LAND

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ALEXANDER S. POPE	2617 Pennsylvania Ave SE DC	JAN 07 1989	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005676

024801 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and will retain the certificate by the hospital or attending physician.

1. DECEASED NAME (TYPE OR PRINT) First: MARY Middle: LILA Last: THOMPSON			2a. DATE OF DEATH Month: 2 Day: 19 Year: 89	2b. HOUR 1:50 P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month: 9 Day: 20 Year: 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Bowie	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 1822 Plymouth Crt., 20716
14. FATHER'S NAME First: William Middle: J. Last: Thompson			15. MOTHER'S MAIDEN NAME First: Sarah Middle: Helen Last: Swan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): ----------		16b. SOCIAL SECURITY NO.: 517-36-6381	17. INFORMANT ADDRESS: James L. Thompson, Same as Line #13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Cardiopulmonary Arrest	2/19/89
DUE TO, OR AS A CONSEQUENCE OF (b)	Urosepsis	2/89
DUE TO, OR AS A CONSEQUENCE OF (c)	Metastatic Glioblastoma Right frontal lobe	12/88

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Paranoid Schizophrenia, ASCVD, Cardiac arrhythmia

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: None	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4/1/50 19__ to 2/19/89 19__, that (I) (we) last saw the deceased alive on 2/19/89 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

22b. SIGNATURE: GB Patrick III MD	DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/19/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): G B Patrick III MD	22e. ADDRESS: 9221 Colesville Road Silver Spring, Md 20910	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02-23-89	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Brentwood, P.G., Maryland
24a. FUNERAL DIRECTOR (NAME AND ADDRESS): FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland	25a. DATE REC'D BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

(1) BP

DHMH - 16 50M 4/83
(VRA 15, 4)

023379 FEB 02 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05677
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial Transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 16

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	ARVILLA SCHAEFFER TIMME
2a. DATE OF DEATH MONTH DAY YEAR	JANUARY 27 1989
2b. HOUR	5:55 A M
3. SEX	FEMALE
4. RACE	CAUCASIAN
5. DATE OF BIRTH MONTH DAY YEAR	OCTOBER 20 1907
6. AGE (IN YEARS LAST BIRTHDAY)	81 YRS.
IF UNDER 1 YEAR MONTHS DAYS	
IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MICHIGAN
7b. CITIZEN OF WHAT COUNTRY?	UNITED STATES
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY MD.
10. CITY OR TOWN OF DEATH	BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	NAVAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	SOCIAL WORKER
12b. KIND OF BUSINESS OR INDUSTRY	Orphanage
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND
13b. COUNTY	MONTGOMERY
13c. CITY OR TOWN	BETHESDA
13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET ADDRESS / ZIP CODE	5101 RIVER ROAD 20816
14. FATHER'S NAME FIRST MIDDLE LAST	Elmer Ellsworth Schaeffer
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Frances Estella Ward
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO
(IF YES, GIVE WAR OR DATES)	-
16b. SOCIAL SECURITY NO.	225-52-5865
17. INFORMANT ADDRESS	CHARLES TIMME, 5101 RIVER ROAD, BETHESDA, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BLADDER CANCER
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 25, 19 89, to JANUARY 27, 19 89, that (I) (we) last saw the deceased alive on JANUARY 27, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED
D B Robinson	MD		27 JAN 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	D. B. ROBINSON, LCDR, MC, USN	22e. ADDRESS	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY
Cremation	Jan 31, 1989	Mt. Comfort Crematory	Alexandria, Alexandria, VA
24. FUNERAL DIRECTOR NAME	Joseph Gawler's Sons, Inc.	ADDRESS	5130 Wisconsin Av NW, Washington, DC 20016
25a. DATE REC'D. BY REGISTRAR	FEB 02 '89	25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall

025378 MAR 13 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056 73

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROBERT	MIDDLE: WILLIAM	LAST: TRABUCHI	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 19, 1989	2b. HOUR: 11:56PM
3. SEX: MALE	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: OCTOBER 26, 1956	6. AGE (IN YEARS LAST BIRTHDAY): 32 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY, MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NIH, THE CLINICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dentist	12b. KIND OF BUSINESS OR INDUSTRY: Self Employed	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
NEW JERSEY	Cumberland	VINELAND	YES ☒ NO ☐	1527 WASHINGTON AVE. / 08360

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	P.	Trabuchi	Nancy		Gerhan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	152 36 8461	Susan Ann Trabuchi	1301 S. Lincoln Ave. Vineland, N.J. 08360

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY FAILURE SECONDARY TO TUMOR COMPRESSION OF THE LUNG

DUE TO, OR AS A CONSEQUENCE OF (b): HYPOXEMIA

DUE TO, OR AS A CONSEQUENCE OF (c): HODGKIN'S DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: DAYS / YEAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that ☒ (this hospital) attended the deceased from February 3 19 89, to February 19 19 89 that ☒ (we) last saw the deceased alive on February 19 19 89, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	2-7-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GEORGE DANIEL MARTICH	NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MD 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	February 24, 1989	Seaside Crematory	Palermo/Cape May/New Jersey

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Homes/ Bethesda- Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland	FEB 21 '89	Julia Davidson-Randall

BP 15

DHMH 16 60M 7/84 (VRA 75, 4)

024071 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005679
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Jake	MIDDLE: S.	LAST: Tracy	2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ MONTH DAY YEAR: 2-9-89		2b. HOUR: M	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 25, 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-9- 1989	2d. HOUR: 3:35P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐				9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY:	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montg.	Silver Spring	YES ☐ NO ☐	8906 Pennsylvania Ave./ 20910

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
FIRST / MIDDLE / LAST: Charles Tracy	FIRST / MIDDLE / LAST: Etta Strothers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-03-8052	17. INFORMANT: Sadie A. Tracy (wife)	ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8/50

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 2-9-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/fixed object collision
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM ETC.): parking garage lot	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: Grubb Road & E.W. Highway, Silver Spring, Montgomery Co. MD

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Golle Jr. M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-10-89

VC EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr., M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-15-89	Ash Memorial Cemetery	Sandy Spring, Montg, MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George R. Snowden Rockville, MD 20850	FEB 13 '89	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M DHMH - 17 (VR A15 ME (5))

BP 5

reorder 5

023854 FEB 25 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05630 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alkinoi	MIDDLE	LAST: Trembelas	2a. DATE OF DEATH MONTH DAY YEAR: 2-3-89	2b. HOUR: 1230 PM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 10 27 1900	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Greece	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Collingswood	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN: WASHINGTON, D.C.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 4426-42nd STREET, N.W. (20016)
14. FATHER'S NAME FIRST: ANTHONY	MIDDLE	LAST: KONTAZACKIS	15. MOTHER'S MAIDEN NAME FIRST: (NOT AVAILABLE)	MIDDLE / LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578-46-7204D	17. INFORMANT: ANTHONY P. TREMBELAS, WASHINGTON, D.C.	ADDRESS: 4426-42nd STREET, NW 20016

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PARKINSONS DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 27 JAN 19 89, to 3 FEB 19 89, that (I) (~~saw~~) last saw the deceased alive on 2 FEB 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~saw~~ did) (~~did not~~) view the body after death.

22b. SIGNATURE: Walter E. Gooch MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 3 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WALTER E. GOOCH MD — 22e. ADDRESS: 2309 SHOREFIELD RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEBRUARY 6, 1989	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY	23d. LOCATION CITY OR TOWN: SUITLAND, COUNTY: PRINCE GEORGES, STATE: MARYLAND
24. FUNERAL DIRECTOR NAME: ROBERT A. PUMPHREY FUNERAL HOME, INC. ADDRESS: 300 W. MONTGOMERY AVENUE, ROCKVILLE, MARYLAND		25a. DATE REC'D. BY REGISTRAR: FEB 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 3

DHMH-16 50M (7/81) (VRA 15, 4)

024302 FEB 29 89

FOR LOCAL REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 5 6 8 1
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
THOMAS	HOWARD	TUCKER	2	25	19 89	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	White	March 7, 1949	39 YRS.			2 25 19 89	9:43 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XXX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, D. C.	U. S. A.		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General Hospital	Camera Man	Photography

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES XXX NO ☐	13e. STREET ADDRESS 20832
Maryland	Montgomery	Olney		17718 King William Court

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Sidney		Tucker	Dorothy		Goldberg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	Vietnam	215-46-2610	Michael B. Tucker 14855 Fireside Drive, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-26-89

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/27/1989	Judean Memorial Gardens	Olney, Montgomery, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		MAR 1 - 1989	[signature]

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025369 MAR 16 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 - 005682 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALINE	MIDDLE: E	LAST: TURNER	2a. DATE OF DEATH MONTH: 02 DAY: 18 YEAR: 89	2b. HOUR: 1:03 P.M.	
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: 09 DAY: 02 YEAR: 27	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS HOURS: MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY	MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Silver Spg - Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: MONTG	13c. CITY OR TOWN: Wheaton	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 12217 Bluhill Rd 20902	
14. FATHER'S NAME FIRST: JAMES MIDDLE: JACKSON LAST:		15. MOTHER'S MAIDEN NAME FIRST: Aline MIDDLE: MC LAST: DONALD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220-56-4635	17. INFORMANT: MARY Turner (Daughter)	ADDRESS: 19862 Wheelwright G'burg, MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio vascular collapse
DUE TO, OR AS A CONSEQUENCE OF (b): cerebral vascular collapse
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ≈ 72°

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-15 19 89, to 2-18 19 89, that (I) (we) last saw the deceased alive on 2-17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alison Norris MD DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-18-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALISON NORRIS

22e. ADDRESS: 14915 Broschart Rd #102 Rockville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-22-89	23c. NAME OF CEMETERY OR CREMATORY: Seneca Cemetery	23d. LOCATION CITY OR TOWN: Germantown, COUNTY: Montg. STATE: MD
24. FUNERAL DIRECTOR NAME: George R. Snowden ADDRESS: Rockville, MD 20850	25a. DATE REC'D BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

023515 FEB 21 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 005683

1. DECEASED NAME (TYPE OR PRINT) FIRST: Emanuel	MIDDLE	LAST: Tsegaye	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH: 2 DAY: 15 YEAR: 89	2b. HOUR			
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: 12 DAY: 30 YEAR: 55	6. AGE (IN YEARS LAST BIRTHDAY): 33 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH: 2 DAY: 15 YEAR: 89	2d. HOUR: 1:00 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ADDIS ABABA	7b. CITIZEN OF WHAT COUNTRY?: ETHIOPIA	8. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.				
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 7700 Old George Town Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CREDIT COLLECTOR	12b. KIND OF BUSINESS OR INDUSTRY: BANK CHEVY CHASE				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Mont	13c. CITY OR TOWN: SILVER SPRINGS	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS: 1421 BLAIR MILL ROAD 20902			
14. FATHER'S NAME FIRST: TSGAYE	MIDDLE	LAST: TESFAMARIYAM	15. MOTHER'S MAIDEN NAME FIRST: FANA	MIDDLE	LAST: TEKILE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 212-98-8063	17. INFORMANT: BEREKET H. SELASSIE	ADDRESS: WASHINGTO DC20003 222 KENTUCKY AVE SE			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound to head
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? XX YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 12:50PM 2-15-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Self inflicted
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): building	21f. LOCATION STREET: 7700 Old Georgetown Road CITY OR TOWN: Bethesda COUNTY: Montgomery County STATE: Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE OF M.D. MEDICAL EXAMINER: [signature] TITLE (SPECIFY): Assistant DATE SIGNED: 2-16-89

VC EXAMINER'S NAME (TYPE OR PRINT): James Kaplan, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/22/89	23c. NAME OF CEMETERY OR CREMATORY: ST. STEPHENS CEMETERY	23d. LOCATION CITY OR TOWN: ADDIS ABABA, COUNTY: ETHIOPIA STATE:

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE	FEB 17 1989	[signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE INCLUDING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M

DHMH - 17 (VR A15 ME (5))

023385 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056884
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Nick	MIDDLE	LAST: Tzanis	2a. DATE OF DEATH MONTH DAY YEAR: January 31, 1989		2b. HOUR: 8:15 AM
3. SEX: Male	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: 12/ 06/ 1899	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GREECE	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY		MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RESTAURANT	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: OLNEY	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS: 18131 MARKSMAN CIRCLE #204	20832
14. FATHER'S NAME FIRST: STAVROS	MIDDLE	LAST: TZANIS	15. MOTHER'S MAIDEN NAME FIRST: FOTENI	MIDDLE	LAST: TELAKIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579-01-2803	17. INFORMANT ADDRESS: LULA N. TZANIS/WIFE/SAME AS 13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours / Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Old myocardial infarction; lung cancer

19a. DATE OF OPERATION: 1/25 and 1/29/89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Hernia repair; arterial revascularization, left leg	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: NA 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): NA	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/15 19 89 to 1/31 19 89, that (I) (we) last saw the deceased alive on 1/31 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ram R Kumar MD — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X] (Pathologist) — 22c. DATE SIGNED: 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): for Mario H. Diaz, M.D.

22e. ADDRESS: 18101 PRINCE PHILLIP DR. OLNEY, MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 3, 1989	23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY	23d. LOCATION CITY OR TOWN: ROCKVILLE	COUNTY: MONTGOMERY STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

023311 FEB 21 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 056855

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Matilda	MIDDLE	LAST: Udoff	2a. DATE OF DEATH MONTH DAY YEAR: Feb. 15, 1989		2b. HOUR: 6:00A M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 17, 1908	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9711 Forest Grove Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Supervisor		12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Sp.	YES ☒ NO ☐	9711 Forest Grove Drive 20910

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Bernard / Udoff	Lillie / Zalmanov

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
NO	578-58-7680	Doris Udoff 9711 Forest Grove Drive Silver Spring, Md. 20910

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC ARREST	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	CARCINOMA of LUNG	8 Yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 74 to Feb 15 19 89, that (I) (we) last saw the deceased alive on Feb 13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE				22c. DATE SIGNED
Herbert Tanenbaum	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Herbert L. TANENBAUM	5480 Wisconsin Avenue Chevy Chase, Md 20815

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-15-89	Metropolitan Crematory	Alexandria, Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ives-Pearson Funeral Homes, Argington, Va.	FEB 16 1989	Julia Davidson Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023547 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR USE ONLY — REG. NO. 89 005686

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: VINCENT	MIDDLE:	LAST: UMUNNA	2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐	MONTH: 2	DAY: 18	YEAR: 1989	2b. HOUR: 10 58 AM
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH: MONTH 01 DAY 01 YEAR 31	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 18 YEAR 1989	2d. HOUR: 10 58 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NIGERIA	7b. CITIZEN OF WHAT COUNTRY?: NIGERIA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐				9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): UNEMPLOYED	12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE: MD	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: KENSINGTON	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 12201 CONTORHILL STREET				
14. FATHER'S NAME: FIRST unavailable	LAST	15. MOTHER'S MAIDEN NAME: FIRST OCHELA	MIDDLE HY	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: unavailable	17. INFORMANT: Godfrey Onicha	ADDRESS: 12201 Contor Hill Kensington, Md.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular Disease — 4 years
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): HYPERTENSION

19a. DATE OF OPERATION: N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): N/A	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Paul A DeVore M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2/18/89

EXAMINER'S NAME (TYPE OR PRINT): PAUL A DEVORE MD ADDRESS: 4203 Queensbury Rd Hyattsville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: March 1, 89	23c. NAME OF CEMETERY OR CREMATORY: Family Cemetery 3447 4455 Lm	23d. LOCATION CITY OR TOWN: Lagos, Nigeria / COUNTY / STATE	
24. FUNERAL DIRECTOR NAME: W. H. Bacon Funeral Home	ADDRESS: Washington DC	25a. DATE REC'D. BY REGISTRAR: FEB 21 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

07/84 25M BP____ DHMH - 17 (VR A15 ME (5))

022465 FEB 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05687
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): FIRST Richard MIDDLE S. LAST Vallaster, Sr.

2a. DATE OF DEATH: MONTH DAY YEAR 02-06-89

2b. HOUR 1145 AM

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH 10 DAY 18 YEAR 17

6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist

12a. USUAL OCCUPATION (TYPE OR PRINT KIND OF WORK DONE MOST OF WORKING LIFE): XXXXXXXXX

12b. KIND OF BUSINESS OR INDUSTRY: D.C. School

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: P.G.

13c. CITY OR TOWN: College Park

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 5116 Lackawanna St. 20740

14. FATHER'S NAME: FIRST Benjamin MIDDLE LAST Vallaster

15. MOTHER'S MAIDEN NAME: FIRST Alice MIDDLE LAST Davenport

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 150-07-8520

17. INFORMANT: Irma Vallaster (wife) ADDRESS: same as # 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO RESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Intractable Ventricular fibrillation

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Artery Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/15 19 89 to 2/6 19 89, that (I) (we) last saw the deceased alive on 2/6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have) (did not) view the body after death.

22b. SIGNATURE: A Dabelam MD. DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABRAHAM B. DABELAM MD

22e. ADDRESS: 4404 Queensbury Rd Riverdale

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-10-1989

23c. NAME OF CEMETERY OR CREMATORY: Md. Veterans Cemetery

23d. LOCATION: CITY OR TOWN Cheltenham COUNTY P.G. STATE Md.

24. FUNERAL DIRECTOR: NAME Donald V. Borgwardt ADDRESS 4400 Powder Mill Rd. Beltsville, Md. 20705

25a. DATE REC'D. BY REGISTRAR: FEB 09 1989

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024606 MAR -3 89 dr

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 8 0 5 6 8 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Angelo	MIDDLE: P.	LAST: Vasos	2a. DATE OF DEATH MONTH DAY YEAR: February 26, 1989	2b. HOUR: 4:30PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 25, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Greece	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: S.S.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Restauranteur	12b. KIND OF BUSINESS OR INDUSTRY: Chef

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Mont.	S.S.	YES [X] NO [ ]	2092 1521 Heather Hollow Drive

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Panagiotis / / Vasos	Theonis / / Koureiakos		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes / WWI	318 12 0933	Kathryn Vasos (Wife)	Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Bronchopneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
None		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M./P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
[ ]	19	

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 2/9, 19 89, to 2/26, 19 89, that (I) (we) last saw the deceased alive on 2/26, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Jerome J. Schnapp M.D.	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/27/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Jerome Schnapp	22e. ADDRESS: 11161 New Hamp. Ave. S.S. Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3/2/89	Gate of Heaven	S.S. / Mont / Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.	MAR 1 - 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

item 14, film g648

23648 FEB 28 89 FOR STATE REGISTRAR 2-24-89 IJ.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 82 056893

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary MIDDLE: Elizabeth LAST: ~~Vaughn~~ Vaughan				2a. DATE OF DEATH MONTH DAY YEAR: February 12, 1989	2b. HOUR: 10:45 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 26, 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Gaithersburg	YES ☒ NO ☐	201 Russell Avenue / 20877

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	Bascomb	~~Vaughn~~ VAUGHAN	Louisa	Jane	Davis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		407-30-8716	Gabie T. Earll,	3608 Cardiff Road Chevy Chase, MD 20815

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ruptured thoracic aneurysm — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 hrs

DUE TO, OR AS A CONSEQUENCE OF (b): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD, ASHD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES XX NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 18, 19 84, to Feb 12, 19 89 that (I) (we) last saw the deceased alive on Jan 31, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James R. Moore Jr. — 22e. ADDRESS: 207 Brookes Ave Gaithersburg MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2-13-89	Suburban Crematory	Silver Spring, Maryland

24. FUNERAL DIRECTOR NAME: Rapp Funeral Services, P. A. ADDRESS: 933 Gist Avenue, Silver Spring, MD. 20910 — 25a. DATE REC'D. BY REGISTRAR: FEB 17 1989 — 25b. REGISTRAR'S SIGNATURE: Lilia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

023757 FEB 26 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005690

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
IRVING	I.	WAGNER	FEBRUARY 17, 1989	4:30P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	FEBRUARY 22, 1915	73 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
NEW YORK	U. S. A.		MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	9902 HEDIN DRIVE	BUDGET ANALYST	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE
MARYLAND	MONTGOMERY	SILVER SPRING	XX	9902 HEDIN DRIVE 20903

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ELIAS		WAGNER	SADIE		ZAUSNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		125 01 6389	JULIE WAGNER,	9902 HEDIN DRIVE SILVER SPRING, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 13, 19 89 to Feb 17, 19 89, that (I) (we) last saw the deceased alive on Feb 17, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE George Orr M.D. DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 2-18-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE ORR, M. D.

22e. ADDRESS 6525 BELCREST ROAD HYATTSVILLE, MARYLAND 20782

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	2/20/1989	MOUNT LEBANON CEMETERY	ADELPHI, PR. GEO., MARYLAND

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME	232 CARROLL STREET, N. W., WASHINGTON, D. C.	FEB 22 1989	Gloria Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the Bureau's transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

023749 FEB 26 89

Item: 21d per ME G-652 6/21/89 CG

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005691
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Tanya	MIDDLE: M.	LAST: Walker	2a. DATE OF DEATH KNOWN [XX] ESTIMATED [ ] MONTH: 2 DAY: 15 YEAR: 19 89	2b. HOUR: M		
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH: 6 DAY: 7 YEAR: 1965	6. AGE (IN YEARS LAST BIRTHDAY): 23 YRS.	IF UNDER 1 YR. MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN:	2c. DATE PRONOUNCED DEAD MONTH: 2 DAY: 15 YEAR: 19 89	2d. HOUR: 1:00P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.				
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 7700 Old Georgetown Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teller	12b. KIND OF BUSINESS OR INDUSTRY: Banking				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince George's	Fort Washington 20744	YES [ ] NO [X]	2430 Corning Ave.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Lilton		Walker	Ruth		Cummings

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	--------	099-56-6415	New York, New York 10039 3A Sandra Bland 159-48 HarlemRiver Drive, Apt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Gunshot wound of head

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [XX] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	12:50PM 2-15-89	Subject shot

21d. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [XX]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	lunch room	7700 Old Georgetown Road, Bethesda, Montgomery County, MD

22a. I certify that I took charge of the remains described above, held an Autopsy [XX] Inspection [ ] Inquiry [ ] and in my opinion death resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [XX] Undetermined manner [ ].

ACTUAL SIGNATURE OF MEDICAL EXAMINER: [signature] TITLE (SPECIFY): Assistant DATE SIGNED: 2-16-89

VC EXAMINER'S NAME (TYPE OR PRINT): James Kaplan, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-22-89	Ferncliff Cemetery	Hartsdale, WestChester, New York

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Marzullo Funeral Service	Upperco, Maryland	FEB 22 1989	Lisha Davidson-Randall

TO MEDICAL EXAMINER: (1) THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGES 1 AND 2 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 05692

1. DECEASED NAME (TYPE OR PRINT): First Tilman Middle Last Walther — TILMAN WALTHER
2a. DATE OF DEATH: Month Day Year: 2-9-89
2b. HOUR: 2200 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Month Day Year: March 18, 1945
6. AGE (IN YEARS LAST BIRTHDAY): 43 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Germany
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE Adventist Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant
12b. KIND OF BUSINESS OR INDUSTRY: High tech. Radar Contractor

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 209 Croydon Avenue / 20850

14. FATHER'S NAME: First George Middle Last Walther
15. MOTHER'S MAIDEN NAME: First Ingeborg Middle Last Bohnet
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 527-68-9607
17. INFORMANT ADDRESS: Sakineh H. Walther, Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 Min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (c): Left upper lobe pneumonia — 4-5 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): S/P Heart transplant (1983)

19a. DATE OF OPERATION: 11-9-1983
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Cardiomyopathy
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-78 to 2-9-89, that (I) (we) last saw the deceased alive on 2-9-89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: K.S. Kim — DEGREE: M.D. — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): KWANG S. KIM
22e. ADDRESS: 50 W. Edmonston Dr. Rockville MD 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-13-89
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION CITY OR TOWN COUNTY STATE: Silver Spring, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910
25a. DATE REC'D. BY REGISTRAR: FEB 17 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] should be detached for use as the burial-transit permit. Then please [illegible] with the State Dept. of Health and Mental Hygiene prior to burial, [illegible]

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025291 MAR 14 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05693
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: JO ANN BRADSHAW WARD			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 14 1989	2b. HOUR: 5:24 P M
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: AUGUST 27 1947	6. AGE (IN YEARS LAST BIRTHDAY): 41 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY, MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DISTRIBUTOR	12b. KIND OF BUSINESS OR INDUSTRY: NEWSPAPER

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	GAITHERSBURG	YES [ ] NO [X]	16512 ROUNDABOUT DRIVE/20878

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
JACK STANLEY BRADSHAW	IRENE KARATZOU		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
YES / 1965-1967	089-38-9433	STEVE WARD, 16512 ROUNDABOUT DRIVE, GAITHERSBURG, MD 20878	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SUBARACHNOID HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [XX]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that [X] (this hospital) attended the deceased from FEBRUARY 13, 19 89, to FEBRUARY 14, 19 89, that (I) [XX] last saw the deceased alive on FEBRUARY 14, 19 89, and that in [XX] (our) opinion death occurred on the date and hour and from the causes stated above, [X] (we) (did) [XXX] view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Albert A Cook	M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	15 Feb 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): A. COOK, LT, MC, USNR	22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	February 17, 1989	Gate of Heaven Cemetery	Silver Spring Maryland

24. FUNERAL DIRECTOR NAME, ADDRESS: Robert A. Pumphrey Funeral Homes/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 16'89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 12+ 1 Stales

DHMH - 16 50M 1/81 (VRA 15, 4)

025361 MAR 16 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005694
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Hazel	MIDDLE: R.	LAST: Weber	2a. DATE OF DEATH MONTH DAY YEAR: 02-19-89	2b. HOUR: 4:55 P.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 14, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK DONE FOR MOST OF WORKING LIFE): Retired-Self Employed	12b. KIND OF BUSINESS OR INDUSTRY: Diner		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES ☒ NO ☐	1229 Gladstone Drive 20851

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Walter / Garrison	Mary / Jane / Wilbert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	**(IF YES, GIVE WAR OR DATES)**	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT ADDRESS**
No	-----	142-09-6281	Carolyn McCord (daughter) same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): decubiti - cerebrovascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/13 19 89 to 2/19 19 89, that (I) (we) last saw the deceased alive on 2/19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
John R. Melnick	MD	☐ ☒ ☐	2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Melnick MD	911 Russell Ave. Gaithersburg Md 20879

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/24/89	Overlook Cemetery	Bridgeton, New Jersey

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852	FEB 22 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the non-transmittal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005695

022460 FEB 13 89

1. DECEASED NAME (TYPE OR PRINT): FIRST JANET MIDDLE L. LAST WEIS
2a. DATE OF DEATH: MONTH 2 DAY 8 YEAR 89
2b. HOUR: 6:20 A.M.
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH 9 DAY 23 YEAR 06
6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA.
7b. CITIZEN OF WHAT COUNTRY?: U.S.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: WHEATON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MANOR CARE WHEATON
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECRETARY
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: TAKOMA PARK
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 910 PROSPECT AVE 20912

14. FATHER'S NAME: FIRST WILLIAM MIDDLE LAST HESS
15. MOTHER'S MAIDEN NAME: FIRST ELIZABETH MIDDLE LAST CURTIN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 220-34-9889
17. INFORMANT: VIVIENNE I. GROSSNICKLE ADDRESS: 900 PROSPECT AVE. TP

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer rectum with metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/10/87 19 87 to 2/8 19 89 that (I) (we) last saw the deceased alive on 2/8 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) perform autopsy on the body after death.
22b. SIGNATURE: Myron L Lenkin DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MYRON L. LENKIN
22e. ADDRESS: 2309 SHORE FIELD RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 13. 1989
23c. NAME OF CEMETERY OR CREMATORY: CONESTOGA METH. CHURCH CEMETERY
23d. LOCATION CITY OR TOWN: CONESTOGA COUNTY: PA.
24. FUNERAL DIRECTOR NAME AND ADDRESS: Takoma Funeral Home, 754 Carroll St. N.W. Washington DC
25a. DATE REC'D BY REGISTRAR: FEB 09 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, poisoning or violence, in any event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

024426 MAR - 2 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 056996
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: William	MIDDLE: A	LAST: Whaley	2a. DATE OF DEATH MONTH: 02	DAY: 19	YEAR: 89
2b. HOUR: 12:15 A M					
3. SEX: M	4. RACE: B	5. DATE OF BIRTH MONTH: 10	DAY: 15	YEAR: 19	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Richland, Eastover U.S.A.	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Takoma Park, Md. (Mont. County) MD		
10. CITY OR TOWN OF DEATH: Takoma Park, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Teacher	12b. KIND OF BUSINESS OR INDUSTRY: High School		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George	13c. CITY OR TOWN: Adelphi	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 9276 Adelphi Rd., #11	20783
14. FATHER'S NAME FIRST: Elias	MIDDLE: Whaley	LAST	15. MOTHER'S MAIDEN NAME FIRST: Fannie	MIDDLE: Johnson	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 248-09-4653	17. INFORMANT: Verneal M. Whaley	ADDRESS: 9276 Adelphi Road, #11 Adelphi, Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Bleeding and Neuropathy
DUE TO, OR AS A CONSEQUENCE OF (c): Disseminated intravascular Coagulopathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-33-1988 to 2-16-1989, that (I) (we) last saw the deceased alive on 2-17-1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. YUSUF	22e. ADDRESS: 345 FORT MEADE ROAD. LAUREL. MD. 20707		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/23/89	23c. NAME OF CEMETERY OR CREMATORY: Rock Hill	23d. LOCATION CITY OR TOWN: Columbia COUNTY: (Richland) STATE: S.C.	
24. FUNERAL DIRECTOR NAME: Velma E. Brock	ADDRESS: Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E., Wash., D.C.	25a. DATE REC'D. BY REGISTRAR: FEB 27 1989	25b. REGISTRAR'S SIGNATURE: Erika Davidson-Randall	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

022278 FEB 10 89

89 05697
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Jeanette — MIDDLE: S. — LAST: WHITE

2a. DATE OF DEATH — MONTH: 2 — DAY: 4 — YEAR: 1989

2b. HOUR: 12 20 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: April — DAY: 28 — YEAR: 1908

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Exec. Secty.

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 301 Russell Ave. 20877

14. FATHER'S NAME — FIRST: Frederick — MIDDLE — LAST: Schumacher

15. MOTHER'S MAIDEN NAME — FIRST: Anna — MIDDLE: M. — LAST: Nanlance

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-09-9343

17. INFORMANT — ADDRESS: William H. White Seminole Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ventricular fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic ventricular arrhythmias — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Chronic organic brain syndrome

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/13 19 86 to 2/4 19 89 that (I) (we) last saw the deceased alive on 1/30 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Byrl D. Johnson — DEGREE: MD — ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BYRL D. JOHNSON

22e. ADDRESS: 911 N. Russell Ave. Gaithersburg, Md. 20879

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2-6-89

23c. NAME OF CEMETERY OR CREMATORY: Greenmount

23d. LOCATION — CITY OR TOWN: Balto. — COUNTY — STATE: Md.

24. FUNERAL DIRECTOR — NAME: Henry W. Jenkins & Sons Co., Balto., Md — ADDRESS: 4905 York Rd.

25a. DATE REC'D. BY REGISTRAR: FEB 8 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson Rendos

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the [illegible] physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit [illegible] pages. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Item #1 Film G648 2/20/89

023137 FEB 17 88

FOR STATE REGISTRAR cg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005698
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ~~Tova~~ Toba	MIDDLE	LAST: Wilensky	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH 2 DAY 9 YEAR 19 89		2b. HOUR M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 1, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
2c. DATE PRONOUNCED DEAD MONTH 2 DAY 9 YEAR 19 89					2d. HOUR 10:18 P. M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Israel	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1316 Fenwick Lane, #1114	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Executive Secretary-Govt.	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 1316 Fenwick Lane, #1114	20910
14. FATHER'S NAME FIRST: Samuel	MIDDLE: Aaron	LAST: Miller	15. MOTHER'S MAIDEN NAME FIRST: Pearl	MIDDLE	LAST: Handleman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 216 01 6903	17. INFORMANT: Pearl Kruger	ADDRESS: 4740 Conn. Ave. Wash., D.C. 20008 NW	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): None
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2/10/89

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS: 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL: Burial	23b. DATE: Feb.12,1989	23c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon Cemetery	23d. LOCATION CITY OR TOWN: Adelphi,	COUNTY: Md. STATE
24. FUNERAL DIRECTOR NAME / ADDRESS: Ives-Pearson Funeral Homes Falls Church, Va. 22046		25a. DATE REC'D. BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: [signature]	

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023387 FEB 22 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 056997

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ANITA	MIDDLE: C.	LAST: Williams	2a. DATE OF DEATH MONTH: 1	DAY: 29	YEAR: 89
2b. HOUR: 11:45 P M					
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: MAY	DAY: 7	YEAR: 1917	
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): RANDOLPH HILLS NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SCHOOL CROSSING GUARD	12b. KIND OF BUSINESS OR INDUSTRY: MONT COUNTY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: WHEATON	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 11602 VIERS MILL ROAD 20902	
14. FATHER'S NAME FIRST: ATILLIO	MIDDLE:	LAST: CASTELLAN	15. MOTHER'S MAIDEN NAME FIRST: PRESEDA	MIDDLE:	LAST: VIOLA
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 226-26-0691	17. INFORMANT ADDRESS: JOYCE WILLIAMS/DAUGHTER/SAME AS 13		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Alzheimer's disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 16 yrs
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/24, 19 88, to 1/29, 19 89, that (I) (we) last saw the deceased alive on 1/25, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George Kenton, MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE S. KENTON — 22e. ADDRESS: 10620 Georgia Ave, S.S., MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB 1, 1989	23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.	23d. LOCATION CITY OR TOWN: SILVER SPRING	COUNTY: MONT	STATE: MD
24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

025275 MAR 1 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05700
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Edith	MIDDLE: Josephine	LAST: Williams	2a. DATE OF DEATH: MONTH 02 / DAY 14 / YEAR 89	2b. HOUR: 9:43 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: MONTH 1 / DAY 13 / YEAR 12	6. AGE (IN YEARS LAST BIRTHDAY): 77 ~~76~~ YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.			
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dept. of Education	12b. KIND OF BUSINESS OR INDUSTRY: US Govt			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 1000 Daleview Dr. 20901		
14. FATHER'S NAME: FIRST Charles / MIDDLE William / LAST Williams		15. MOTHER'S MAIDEN NAME: FIRST Sadie / MIDDLE / LAST Souder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220 09 4813	17. INFORMANT: Margaret Williams Schell	ADDRESS: Koninginnegracht 55 2514 AE The Hague Netherlands		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	1 minute
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Rheumatoid Arthritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/8/89, 19 89, to 2/14, 19 89, that (I) (we) last saw the deceased alive on 2/12, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen L Schechter	DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/14/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen L. Schechter	22e. ADDRESS: 8218 Wisconsin Ave., Bethesda, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/20/89	23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cem.	23d. LOCATION: CITY OR TOWN Wash., DC / COUNTY / STATE	
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 WI Ave. NW Wash., DC 20016	25a. DATE REC'D BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024313 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057 01
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Marie	Louise	Wilson	February 24, 1989	9:40pm

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	04 08 22	66 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
New Uork	American		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General Hospital	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montg.	Clarksburg	YES ☐ NO ☒	12112 Fountain Drive 20871

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Arthur		Aigeltinger	Genevive		Yale

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		032-34-9842	Susan Wilson Smith	Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-12-89

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia — 2-12-89

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/24/89, 19__, to 2/24, 19 89, that (I) (we) last saw the deceased alive on Was Did not see it. 19__ and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. (Seen by WKumar 2-24-89 - alive)

22b. SIGNATURE DEGREE: WJ Jones MD Covering for K-Kumar — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-25-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM O JONES MD — 22e. ADDRESS: 3701 Rossmoor Blvd Silver Spring MD 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	3/3/1989	Westview Mem. Pk.	Baltimore,	Maryland	

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Olin L. Molesworth, P.A.,	Damascus, Md.	MAR 1 — 1989	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

023654 FEB 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05702
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbons pressed. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dora	MIDDLE: —	LAST: Windisch	2a. DATE OF DEATH MONTH: 2	DAY: 13	YEAR: 89
2b. HOUR: 3:30 P.M.					
3. SEX: Famele	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: March 18, 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Roumania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner (Ret.)	12b. KIND OF BUSINESS OR INDUSTRY: Grocery		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES ☒ NO ☐	6121 Montrose Road (20852)

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
(Unknown)			(Unknown)		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	-----	577-56-3892A	Irv Favin; Nephew; 820 Kersey Road; Silver Spg	Md. 20902

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPIRATION PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b): MULTI-INFARCT DEMENTIA
DUE TO, OR AS A CONSEQUENCE OF (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): —

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 1/27/89 to 2/13/89, that (I) (we) last saw the deceased alive on 2/13/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M D Patel	M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
D.D. PATEL	6121 MONTROSE RD, ROCKVILLE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/15/89	Beth Sholom Cemetery	Capitol Heights, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	FEB 17 1989	Julia Davidson-Kimball

BP ____

DHMH - 16 50M 1/81 (VRA 15, 4)

B22412 FEB 13 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005703

1. DECEASED NAME (TYPE OR PRINT): Martha B. Wintringham

2a. DATE OF DEATH: 2/4/89

2b. HOUR: 2:30PM

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: May 19, 1904

6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Potomac

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 20854 12317 Rivers Edge Drive

14. FATHER'S NAME: UNKNOWN Bowers

15. MOTHER'S MAIDEN NAME: Daisy Rice

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 137-32-2875

17. INFORMANT: Tylee Stoesser/Daughter/

ADDRESS: Same as Item 13a-13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Bronchitis - Pulmonary Emphysema Type

DUE TO, OR AS A CONSEQUENCE OF (c): Cachexia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan. 1, 19 88, to Feb. X, 19 89, that (I) (we) last saw the deceased alive on Feb. 2, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD MS PA

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Feb. X/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Azad S. Vaziri M.D. PA

22e. ADDRESS: 10,000 Falls Rd. Potomac, Md. 20854

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: February 8, 1989

23c. NAME OF CEMETERY OR CREMATORY: Somerset Hills Crematory

23d. LOCATION: CITY OR TOWN: Bernards Township COUNTY: New Jersey STATE:

24. FUNERAL DIRECTOR NAME: William A. Bradley & Son

ADDRESS: 345 Main Street, Chatham. New Jersey 07928

25a. DATE REC'D. BY REGISTRAR: FEB 8 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024094 FEB 28 89

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05704 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: John E. Wright	2a. DATE OF DEATH MONTH DAY YEAR: 2/7/89	2b. HOUR: 1857 PM	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 1-1-21	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Takoma Pk. Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LABORER	12b. KIND OF BUSINESS OR INDUSTRY: Construction
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: MONTGO.	13c. CITY OR TOWN: ROCKVILLE	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS / ZIP CODE: 222 FREDERICK AVE. 20850
14. FATHER'S NAME FIRST MIDDLE LAST: UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: MATTIE L. GREEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 227-46-9383	17. INFORMANT: VIRGIE V. WRIGHT (WIFE)	ADDRESS: 309 A - DAWSON AVE ROCKVILLE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): acute respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO, OR AS A CONSEQUENCE OF (b): Hepatoma — 4 mnths

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chymi renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 7, 19 86, to Feb 7, 19 89, that (I) (we) last saw the deceased alive on Feb 7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark S Rosen MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Mark Rosen — 22e. ADDRESS: Silver Spring, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-11-89	23c. NAME OF CEMETERY OR CREMATORY: LINCOLN PK. CEM.	23d. LOCATION CITY OR TOWN: ROCKVILLE COUNTY: MONTG. STATE: M.D.	
24. FUNERAL DIRECTOR NAME: GEORGE R. SNOWDEN ADDRESS: 246 N. WASH. ST. ROCKVILLE, MD.	25a. DATE REC'D. BY REGISTRAR: FEB 10 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23602 FEB 23 '89

1- FOR STATE REGISTRAR

REG. NO. 89 005705

1. DECEASED NAME (TYPE OR PRINT): FIRST Marie; MIDDLE J.; LAST Wyatte

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 2/3 DAY YEAR 19 89 — 2b. HOUR M

3. SEX: Female — 4. RACE: Black — 5. DATE OF BIRTH: MONTH Apr. DAY 15, YEAR 1894 — 6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 2/3 DAY YEAR 19 89 — 2d. HOUR 1:18 P. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD

10. CITY OR TOWN OF DEATH: Silver Spring — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 8319 - 16th Street — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House worker — 12b. KIND OF BUSINESS OR INDUSTRY: Real Estate Office

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] — 13e. STREET ADDRESS: 8319 - 16th Street 20910

14. FATHER'S NAME: FIRST George MIDDLE LAST Wyatte

15. MOTHER'S MAIDEN NAME: FIRST Betty MIDDLE E. LAST Eggleston

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-16-7111

17. INFORMANT — ADDRESS: Mrs Mable F. Palmer: 205 Fairway Dr Locust Grove, VA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial disease	
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last. (b)	chronic myocardial disease.	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): None

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2/7/89

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. — ADDRESS: 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2-9-89 — 23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Cem. — 23d. LOCATION CITY OR TOWN: Suitland COUNTY: Md. STATE

24. FUNERAL DIRECTOR NAME: Marshall's Funeral Home — ADDRESS: 4217 9th St NW: Washington, D.C.

25a. DATE REC'D. BY REGISTRAR: FEB 15 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Dickson Rudasa

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE USING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

24298 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005706

1. DECEASED NAME (TYPE OR PRINT): FIRST Adeline MIDDLE Helen LAST Yehnert

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — MONTH Feb DAY 25 YEAR 1989

2b. HOUR 9:55 AM

3. SEX: F

4. RACE: W

5. DATE OF BIRTH: MONTH DAY YEAR Feb., 18, 1910

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR Feb 25 1989 — HOUR 9:55 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? U S A

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Tak Park

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 8 Crescent Pl

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Mont.

13c. CITY OR TOWN: Tak Park

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 8 Crescent Pl. 2291

14. FATHER'S NAME: FIRST James MIDDLE H. LAST Wilson

15. MOTHER'S MAIDEN NAME: FIRST Sarah MIDDLE LAST Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 194-09-1798

17. INFORMANT ADDRESS: Harry M. Yehnert-Same as items#13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Inf

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER DATE SIGNED: Feb 25 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers ADDRESS: 1919 Seminary Rd., S. S. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/26/89

23c. NAME OF CEMETERY OR CREMATORY: B/W Crematory

23d. LOCATION CITY OR TOWN: Laurel COUNTY: P. G. Co. STATE: Md

24. FUNERAL DIRECTOR NAME: Takoma Funeral Home ADDRESS: 254 Carroll St.NW, Wash., D. C.

25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989

25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024141 FEB 29 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005707 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST: Rocio (Rocile)	MIDDLE: A.	LAST: Yepez				2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR: 1-31-1989		2b. HOUR: M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: March 17,1966	6. AGE (IN YEARS LAST BIRTHDAY): 22 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 1-31-1989		2d. HOUR: 1:15A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ecuador	7b. CITIZEN OF WHAT COUNTRY?: Ecuador	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐				9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary		12b. KIND OF BUSINESS OR INDUSTRY: Auto Import/Export

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Gaithersburg	YES ☒ NO ☐	Gaithersburg,Maryland 130 Duvall Lane, #202 (20877)

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Mario / / Yepez	Bertha / / Munoz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	212-04-8935	Bertha M. Yepez, Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound to head
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	1:15AM 1-31-89	Subject shot

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	home	130 Duvall Lane,Gaithersburg, Montgomery Co. Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐.

ACTUAL SIGNATURE OF M.D. MEDICAL EXAMINER: [signature] TITLE (SPECIFY): Acting Deputy Chief DATE SIGNED: 1-31-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 6, 1989	Gate Of Heaven Cemetery	Silver Spring, Montgomery, Maryland

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville,Maryland	FEB 06'89	Julia Davidson-Randall

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

024607 MAR -3 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

REG. NO. 9 0 5 7 0 3

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Margaret	V.	Young	2/27		19 89	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Female	White	Feb. 25, 1924	65 YRS.					2/27 19 89	10:40 A. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Ohio	USA		Montgomery County MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	327 Duxbury Place	Navy Seaman 1st Class	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring		327 Duxbury Place 20904

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Jay	H	Vaughan	Mae		Titus

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes Navy	WWII	286 14 5428	Douglas T. Young (Same as 13E) Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
(b) chronic myocardial disease.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditians, if ony, which gave rise to immediate couse (a) stoting the underlying couse lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
None		

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
		None

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2/27/89

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	3/1/89	Parklawn Cemetery	Rockville	Mont	Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md.	MAR 1 - 1989	Gina Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M

BP

DHMH - 17 (VR A15 ME (5))

024953 MAR 1-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057093
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
EULA	MARTINA	ADAMS	02	18	89	11.04P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	CAU.	SEPT. 8 1908	80 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA	WIDOWED X	PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	SELF EMPLOYED	GROCERY STORE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	CHARLES	WALDORF	YES / NO X	1062 DORSET DRIVE 20602

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
HAL		BADEN	LULY		MURPHY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	----------	214 36 4531	NIECE MARGARET BADEN	1062 DORSET DR. WALDORF, MD. 20602

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	IMMEDIATE CAUSE (a) Sepsis	
	DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Lymphocytic Leukemia	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO

21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from October 19 88 to Feb 18 19 89, that (I) (we) last saw the deceased alive on Feb 18 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Stuart Turkel	MD ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Stuart Turkel MD	7500 Greenway Ctr. Dr. Greenbelt, Md. 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-22-89	ST. PETER's CEMETERY	WALDORF CHARLES MARYLAND

24. FUNERAL DIRECTOR (NAME)	(ADDRESS)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HUNTT FUNERAL HOME, INC.	P.O. BOX 156 WALDORF, MARYLAND	FEB 28 '89	Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

02499-4 MAR - 8 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05710 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Pedro	MIDDLE: C.	LAST: Agustin	2a. DATE OF DEATH MONTH DAY YEAR: February 18, 1989	2b. HOUR: 12:10 PM	
3. SEX: Male	4. RACE: Filipino	5. DATE OF BIRTH MONTH DAY YEAR: February 22, 1922	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Philippine Is.	7b. CITIZEN OF WHAT COUNTRY?: Philippines	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer - Ret.	12b. KIND OF BUSINESS OR INDUSTRY: Farming	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George	13c. CITY OR TOWN: Ft.Washington	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 802 Cornish Street 20744	
14. FATHER'S NAME FIRST: Vicente	MIDDLE:	LAST: Agustin	15. MOTHER'S MAIDEN NAME FIRST: Enriqueta	MIDDLE:	LAST: Unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 545-28-9199	17. INFORMANT: Felizardo Agustin	ADDRESS: 9013 Lynnalan Dr. Ft. Washington, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	3 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Multiple CVA (Strokes)	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary Artery Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from Feb. 16, 19 89, to Feb. 18, 19 89, that I (we) last saw the deceased alive on Feb. 18, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael D. Levine	DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: Feb. 18,1989	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael D. Levine, M.D.	22e. ADDRESS: 7801 Old Branch Ave.#409, Clinton, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal	23b. DATE: 2/18/89	23c. NAME OF CEMETERY OR CREMATORY: Malolos Mem. Cemetery	23d. LOCATION CITY OR TOWN: Malolos COUNTY: Bulacan STATE: Philippine Is	
24. FUNERAL DIRECTOR NAME: George P. Kalas Funeral Home ADDRESS: 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: [illegible]	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023065 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05711
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE	LAST: Albeyaz	2a. DATE KNOWN OF DEATH ☑ ESTIMATED ☐ MONTH DAY YEAR: 2-13 1989	2b. HOUR: M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 15, 1920	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-13 1989	2d. HOUR: 1440 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Turkey	7b. CITIZEN OF WHAT COUNTRY?: Turkey	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.			
10. CITY OR TOWN OF DEATH: Upper Marlboro	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN EITHER FACILITY, GIVE STREET ADDRESS): 15301 Candyhill Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Pr.Geo's	13c. CITY OR TOWN: Upper Marlboro	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 15301 Candyhill Rd., 20772		
14. FATHER'S NAME FIRST / MIDDLE / LAST: UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No.	(IF YES, GIVE WAR OR DATES): ---	16b. SOCIAL SECURITY NO.	17. INFORMANT: Kegham Albeyas	ADDRESS: 15301 Candyhill Rd., Upper Marlboro, Md. 20772		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-Renal disease
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Dialysis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-13-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/16/89	23c. NAME OF CEMETERY OR CREMATORY: St. Thomas Cemetery	23d. LOCATION CITY OR TOWN: Croom COUNTY: (Pr.Geo's) STATE: Md.	
24. FUNERAL DIRECTOR: Richard A. Coleman Funeral Home	ADDRESS: Upper MaRLBORO, Md. 20772	25a. DATE REC'D BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

5 07/84 25M BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 057 12

1. DECEASED NAME (TYPE OR PRINT) — FIRST: VERGIE; MIDDLE: LUCILLE; LAST: ALLAN

2a. DATE OF DEATH (MONTH, DAY, YEAR): February 16, 1989

2b. HOUR: 7:30 a M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH (MONTH, DAY, YEAR): Sept. 29, 1892

6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Iowa

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Hyattsville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2600 Queens Chapel Road, #511

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: P.G.

13c. CITY OR TOWN: Hyattsville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 2600 Queens Chapel, #511 20782

14. FATHER'S NAME — FIRST: Edwin; MIDDLE: E.; LAST: Colip

15. MOTHER'S MAIDEN NAME — FIRST: Lorraine; MIDDLE: ; LAST: Eves

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 578-62-7764

17. INFORMANT (ADDRESS): (Daughter) 4327 Ravesworth Rd. #220 Lorraine McCann Annandale, Maryland 22003

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)		
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebravascular Disease	5 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease. Hypertension.

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M., MONTH, DAY, YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 2, 19 82, to Feb 16, 19 89, that (I) (we) last saw the deceased alive on Jan 24, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. M. Khatri — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 02-16-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Ibrahim Khatri

22e. ADDRESS: 6525 Belcrest Rd., Hyattsville, Md. 20782

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02/18/89

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION — CITY OR TOWN: Brentwood; COUNTY: P.G.; STATE: Maryland

24. FUNERAL DIRECTOR (ADDRESS): Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR: FEB 21 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

023544 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 057 13
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Jerome — MIDDLE: John — LAST: Almo

2a. DATE OF DEATH — MONTH DAY YEAR: 2-4-89

2b. HOUR: 11:10 P.M.

3. SEX: M

4. RACE: Cau

5. DATE OF BIRTH — MONTH DAY YEAR: Feb 25 1912

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.

10. CITY OR TOWN OF DEATH: Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman

12b. KIND OF BUSINESS OR INDUSTRY: Automobile

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Charles

13c. CITY OR TOWN: Waldorf

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: Box 269 Hwy 925 N 20601

14. FATHER'S NAME — FIRST: James — MIDDLE — LAST: Almo

15. MOTHER'S MAIDEN NAME — FIRST: Margaret — MIDDLE — LAST: Garrick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes (IF YES, GIVE WAR OR DATES): 43-46 WWII

16b. SOCIAL SECURITY NO.: 212=12=3169

17. INFORMANT: Jeffrey E Almo — ADDRESS: 7366 Montcalm Dr McLean VA 22102

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Unstable Cardiac rhythm
DUE TO, OR AS A CONSEQUENCE OF (c): Atherosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Multiple Strokes, Renal Shut down, Chronic obstructive Lung Disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-24 19 89 to 2-4 19 89 that (I) (we) last saw the deceased alive on 2-4- 19 89 and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R.A. McConnaughy MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-5-89.

22f. PHYSICIAN'S NAME (TYPE OR PRINT): R.A. McConnaughy M.D.

22e. ADDRESS: 11418 Livingston Rd. Ft. Washington, Md. 20744

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial

23b. DATE: Feb 7 1989

23c. NAME OF CEMETERY OR CREMATORY: St Peter's

23d. LOCATION — CITY OR TOWN: Waldorf — COUNTY: Charles — STATE: MD

24. FUNERAL DIRECTOR — NAME: The Huntt Funeral Home — ADDRESS: PO Box 156 Waldorf MD

25a. DATE REC'D BY REGISTRAR: FEB 06 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 6

DHMH - 16 50M 4/83
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item#16b FilmG649 per funeral Homecg

024992 MAR -8 '89

FOR 1- STATE REGISTRAR 3/29/89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 057114 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ERNEST (Ernest) MIDDLE: EUGENE (E.) LAST: ALSOP (Alsop)

2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐ — MONTH DAY YEAR: Feb 15, 1989 — 2b. HOUR: 2400 M

3. SEX: Male — 4. RACE: Cau. — 5. DATE OF BIRTH MONTH DAY YEAR: Dec. 8, 1921 — 6. AGE IN YEARS (LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: Feb 15 1989 — 2d. HOUR: 2400 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington DC

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.

10. CITY OR TOWN OF DEATH: Riverdale

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk

12b. KIND OF BUSINESS OR INDUSTRY: Air Brakes

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Prince Geo. — 13c. CITY OR TOWN: College Park — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 4711 Berwyn House Road 20740

14. FATHER'S NAME — FIRST: Ernest — MIDDLE: Wesley — LAST: Alsop

15. MOTHER'S MAIDEN NAME — FIRST: Annie — MIDDLE: C. — LAST: Garvey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 579-14-0215

17. INFORMANT — ADDRESS: 5700 36th Avenue, Hyattsville, Mrs. Frances McKenney, Md. 20782

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Inf.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: [signature] M.D. — TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Feb 15, 1989

EXAMINER'S NAME (TYPE OR PRINT): _____ ADDRESS: _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 02-18-89 — 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery — 23d. LOCATION CITY OR TOWN COUNTY STATE: Brentwood, P.G., Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland — 25a. DATE REC'D. BY REGISTRAR: FEB 17 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP____

DHMH - 17 (VR A15 ME (5))

24960 MAR -8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057163 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: KATHRYN	MIDDLE: LUCAS	LAST: ANDERSON	2a. DATE OF DEATH MONTH DAY YEAR: 02-25-89	2b. HOUR: 6 55AM M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 04-18-1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Bank		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. George's	13c. CITY OR TOWN: Bladensburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 5610 Annapolis Road 20710	
14. FATHER'S NAME FIRST: FRank	MIDDLE: R.	LAST: Lucas	15. MOTHER'S MAIDEN NAME FIRST: Josephine	MIDDLE:	LAST: Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 579-12-8774	17. INFORMANT: Flora J. Ogle	ADDRESS: same as #13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIORESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF: (b) ADENOCARCINOMA COLON

DUE TO, OR AS A CONSEQUENCE OF: (c) CACHEXIA

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M. S Nayar	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. M. NAYAR, M.D.	22e. ADDRESS: 3717-38th AVE, BRENTWOOD, MD 20722		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02-28-89	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Brentwood, Pr. George's, Md.	
24. FUNERAL DIRECTOR (NAME) / ADDRESS: Frank Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781	25a. DATE REC'D. BY REGISTRAR: FEB 28 '89	25b. REGISTRAR'S SIGNATURE: Zuha Davidson-Randall		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024751 MAR 7 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057 16
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
ANN		APPUGLIES	Feb	24.	89	623 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
Female	Caucasian	11	05	16	72 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Cleveland, Ohio	U.S.A.		PRINCE GEORGES CO. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CLINTON	SO. MARYLAND HOSPITAL	Homemaker	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Charles	Waldorf	YES ☐ NO ☒	4704 Hummingbird Dr. 20601

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Sam		Barravechia	Rose		Imbordina

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	N/A	578-12-3842	Sam Appuglies	15 Partridge Ct. LaPlata, Md 20646

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular Ectopy (Suspected)

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/28/89 to 2/24/89, that (I) (we) last saw the deceased alive on 2/23/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
S. Josef MD	7501 Surratts Rd Clinton, Md 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	02/27/89	Resurrection Cemetery	Clinton Prince George's MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc.	6633 Old Alexander Ferry Rd Clinton Md 20735	MAR 01 '89	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024220 FEB 27 89

1a FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05717
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: OTIS; MIDDLE: T; LAST: ARMSTEAD		2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 16 1989	2b. HOUR: 1014 PM
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 11-7-07	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Texas	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Hyattsville, Maryland
10. CITY OR TOWN OF DEATH: Hyattsville, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGES MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK DONE FOR MOST OF WORKING LIFE, EVEN IF NOT AT TIME OF DEATH): Railroad Worker	12b. KIND OF BUSINESS OR INDUSTRY: Railroad
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: Cottage City	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 4142 Bunker Hill Rd Cottage City, Md.
14. FATHER'S NAME FIRST: Henry; MIDDLE; LAST: Armstead		15. MOTHER'S MAIDEN NAME FIRST: Millie; MIDDLE; LAST: Armstead	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 453-01-3765	17. INFORMANT: Mrs Louise Armstead	ADDRESS: 4142 Bunker Hill Rd, Mnr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (c): Chronic Obstructive Pulmonary Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive Heart Failure, Hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1988, 19__, to 2-16, 1989, that (I) (we) last saw the deceased alive on 2-16 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-17-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): POOCHIKIAN 22e. ADDRESS: 5632 Annapolis Rd Bladensburg Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial 23b. DATE: 2-89 23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bladensburg, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS: Samuel R. Woodfin Funeral Home 1722 North Capitol St. NW. Wash. D.C. 25a. DATE REC'D BY REGISTRAR: FEB 27 1989 25b. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

025076 MAR -9 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057 18
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ANNETTE	G.	BAIER	FEBRUARY 17, 1989	10:37PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JUNE 9, 1937	51 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
PENNSYLVANIA	USA		PRINCE GEORGE'S COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CAMP SPRINGS	MALCOLM GROW USAF MEDICAL CENTER	HOMEMAKER	HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	P.G. CO.	CLINTON	YES ☒ NO ☐	5912 CLOVERLEAF AVE. / 20735

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WALTER	WALLACE	GODLEWSKI	HARRIET	-	ORZULAK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	NONE	577-50-2727	RICHARD L. BAIER (HUSBAND) SAME AS # 13.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) EMPHYSEMA
DUE TO, OR AS A CONSEQUENCE OF
(c) ANTITRYPSIN DEFICIENCY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 17 FEB 19 89 to 17 FEB 19 89 that (I) (we) last saw the deceased alive on 17 FEB 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED
Joseph A. Cook	MD		18 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JOSEPH A. COOK, CAPT, USAF, MC	MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MARYLAND 20331-5300

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB/22/89	GATE OF HEAVEN CEM.	SILVER SPRING, MONT.CO., MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ROBERT E. WILHELM, INC. SUITLAND, MARYLAND	FEB 23 '89	Julia Davidson-Rondeau

RELEASED BY MEDICAL EXAMINER

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTEND... The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 ... injury, or other traumatic event, the medical examiner must be notified at once.

12

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

023220 MAR 14 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05719
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. The medical examiner must be notified at once if the death certificate is not executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The line required for the death certificate (page 1) may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: Alberta	LAST: BAILEY	2a. DATE OF DEATH MONTH DAY YEAR: 02-24-89
2b. HOUR: 10 22AM M			
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 01 24 17	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S COUNTY MD.
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Nurse	12b. KIND OF BUSINESS OR INDUSTRY: Medical

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P. G.	Upper Marlboro	YES ☐ NO ☒	11411 Brown Road 20772

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Albert		Benningfield	Mary		Maupin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	N/A	404-01-9132	Wendell H. Bailey, Jr. Same as 13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Septic Shock / PULMONARY EMBOLI

DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes Mellitus Hypertension

DUE TO, OR AS A CONSEQUENCE OF (c): Chronic Renal Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

888

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Fracture Hip (L) Side

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
12/22/88	Hip Fracture	YES ☒ NO ☐	YES ☒ NO ☐

20c. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐ ☒	12-21 1988	Fell while walking

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	Home	11411 Brown Road, Upper Marlboro, Pr. Geo Md

22a. I certify that (I) (this hospital) attended the deceased from Feb, 1989, to 2-25, 1989, that (I) (we) last saw the deceased alive on 2-24 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Signature	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	02/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. S. C. Gupta	3503 Perry St. Mt. Rainier Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	02/28/89	Lee Crematory	Clinton Prince George's Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc. 6638 Old Alexander Ferry Rd Clinton, Md 20735	MAR 2 - 1989	Julia Davidson-Randall

DHMH - 16 50M 1/81 (VRA 15, 4)

3/3/89 BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 05720

0248 89 MAR -7 89

1. DECEASED NAME (TYPE OR PRINT) FIRST: EARL MIDDLE: LAST: BALL
2a. DATE OF DEATH MONTH DAY YEAR: 02 18 89
2b. HOUR: 350P M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH MONTH DAY YEAR: 9 14 04
6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES COUNTY MD.
10. CITY OR TOWN OF DEATH: CLINTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SOUTHERN MARYLAND HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY: FED. GOV.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD.
13b. COUNTY: CHARLES
13c. CITY OR TOWN: WALDORF
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET ADDRESS: Rt. 2 Box 260 20603

14. FATHER'S NAME FIRST MIDDLE LAST
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
16b. IF YES, GIVE WAR OR DATES
16c. SOCIAL SECURITY NO.: 105-07-9846
17. INFORMANT ADDRESS: Loretta Ball/same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Urosepsis — 72 hrs
DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma Bladder with Metastasis — 3 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa: Arteriosclerotic Cardiovascular Disease

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from May 19 79 to Feb 18 19 89, that (I (~~we~~) last saw the deceased alive on Feb 18 19 89, and that (I (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.
22b. SIGNATURE: Thomas L Fieldson DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: Feb 22, 1989
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas Fieldson, M.D.
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal
23b. DATE: 2-27-89
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME: State Anatomy Board ADDRESS: Balto., Md.
25a. DATE REC'D. BY REGISTRAR: MAR 1 1989
25b. REGISTRAR'S SIGNATURE: Irene Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024749 MAR -7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05721
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the burial-transit permit has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Costella	MIDDLE	LAST: Barnes	2a. DATE OF DEATH MONTH DAY YEAR: 2 26 89	2b. HOUR: 9:50P M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 9 12 31	6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.	
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Day Care	12b. KIND OF BUSINESS OR INDUSTRY: Child Care

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. George	Ft. Washington	YES ☒ NO ☐	508 Bentwood Dr. 20744

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John		Mills	Mary	L.	Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		577-42-3026	Mary Barnes sAMe as item 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Pulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): Cancer of breast with metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Prolonged bed ridden

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 7-23 19 87, to 2-26 19 89, that (I) (we) last saw the deceased alive on 12-25 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): P.T. PHAM, M.D. — 22e. ADDRESS: 6357 Oxon Hill Rd. Oxon Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3/3/89	Nat. Memorial Park	Laurel / Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.	MAR 01 '89	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

0253.67 MAR 16 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05722 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Prior to burial, cremation, or removal, please remove carbon papers.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST: Carolyn / / Blandford			2a. DATE OF DEATH — MONTH / DAY / YEAR: 2 / 18 / 89	2b. HOUR: 9:45 PM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH — MONTH / DAY / YEAR: 2 / 3 / 13	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.	
10. CITY OR TOWN OF DEATH: Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel-Beltsville Hospital	12a. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF WORKING LIFE): Occupational Therapist	12b. KIND OF BUSINESS OR INDUSTRY: Hospital	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES ☐ NO ☒	4308 Sleaford Road/20814

14. FATHER'S NAME — FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST
William / / Caviness	Effie / / Craven

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
No	577-54-3320	W. Barry Blandford same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CEREBROVASCULAR ACCIDENT

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SEPSIS and possible pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/29 19 88, to 2/18 19 89, that (I) (we) last saw the deceased alive on 2/18 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GREGORY A COMPTON MD	8317 Cherry Lane Laurel MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	February 21, 1989	Union Cemetery	Leesburg / / Virginia

24. FUNERAL DIRECTOR — ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814	FEB 21 '89	Julia Davidson-Randall

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

025007 MAR 1-89 FOR STATE REGISTRAR Film G649 item 6 3-14-89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 05723

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR	2b. HOUR
I'Ann		Blanchette	2-26-89	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Female	Cauc.	Nov. 24, 1944	~~64~~ 44 YRS.			2-26- 19 89	11:55 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Texas	United States		Prince Georges County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bowie	3514 Maybank	Graphic Artist	Hotel

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Bowie	YES ☒ NO ☐	3514 Maybank Street/20715

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Homer	C.	Watson, Jr.	Martha	E.	Richard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		223-62-3815	Martha R. Watson,	4634 N. 26th Street Arlington, VA 22207

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured berry aneurysm
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Marvo F. Hollo Jr. M.D. (OR SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-27-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	3/2/89	Green Hill Cemetery	Stephen's City, Virginia

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	MAR 3 - 1989	Julia Davidson-Randall

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

025341 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057241 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: WALTER	MIDDLE: W.	LAST: BOHAN	2a. DATE OF DEATH: MONTH 02 DAY 19 YEAR 89	2b. HOUR: 6 36P M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH: MONTH DECEMBER DAY 2 YEAR 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET AND NUMBER): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DIRECTOR EAST AREA RED CROSS	12b. KIND OF BUSINESS OR INDUSTRY: AMERICAN		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	PR. GEO.	BOWIE	YES ☐ NO ☐	12531 WINDOVER TURN 20715

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST MICHAEL MIDDLE LAST BOHAN	FIRST JENNY MIDDLE LAST HURLEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		016-03-8719	SON CONNOR W. BOHAN	4909 RIDGEVIEW LANE BOWIE, MD. 20715

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) – acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): metastatic Colon Cancer, Prostate Cancer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from ~~19~~ to ~~19~~, 19__, that (I) (we) last saw the deceased alive on 2/16/89 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
R. Dakheel m.D	M.D	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Riad Dakheel m.D.	14300 Gallant Fox Ln. Bowie, 20715

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
BURIAL	FEB. 23, 1989	ST. GABRIEL'S	POTOMAC MONTGOMERY MARYLAND

24. FUNERAL DIRECTOR: NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901	FEB 24 '89	Julia Davidson-Randall

BP 15

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005725

025087 MAR - 8 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use with the disposition permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
CLARENCE	Theopherous	Booker	FEBRUARY	19	1989	5:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
MALE	White	MAY	13	1895	93 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
CANADA	US		PRINCE GEORGES MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hyattsville	CARROLL MANOR NSG Home	Repairman	Western Union

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	PG	Adelphi	YES ☒ NO ☐	2118 Rolander Street 20783

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Allan		Booker	Effie		Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		578-10-8756	Gladys Darby	2118 Rolander Street Adelphi, Md 20783

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	30 min
DUE TO, OR AS A CONSEQUENCE OF (b)	Unspec.	4 days
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cardiac Arrhythmia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
None		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	22c. DATE SIGNED
Sharon Rose Towns	MD				2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Sharon Rose Towns	5804 Baltimore Ave Hyattsville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	02/22/89	Cedar Hill Cemetery	Suitland	PG	Maryland

24. FUNERAL DIRECTOR (NAME AND ADDRESS)	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781	FEB 23 '89	Julia Davidson-Kendall

(13) BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

024954 MAR 3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05726
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Claude	MIDDLE: William	LAST: BOSWELL	2a. DATE OF DEATH MONTH DAY YEAR: February 22, 1989	2b. HOUR: 1:00 AM	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 6, 1917	6. AGE (IN YEARS EAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Doctor's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor Supervisor	12b. KIND OF BUSINESS OR INDUSTRY: P. G. County		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. George's	Upper Marlboro	YES [ ] NO [X]	16333 Tanyard Road/20772

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
unavailable	Lillian Richardson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	———	216-16-0538	Frances Boswell - same as # 13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): cardiorespiratory failure

DUE TO, OR AS A CONSEQUENCE OF: (b): trauma

DUE TO, OR AS A CONSEQUENCE OF: (c): pneumothorax

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): WA diabetes mellitus, hepatic cirrhosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
[ ]		

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/6 89 to 2/22 89, that (I) (we) last saw the deceased alive on 2/22/89, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Lewis H. Dennis M.D.	6201 Greenbelt Rd., College Park, Md. 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-25-89	Resurrection	Clinton Pr. Geo. Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home	P. O. Box 156 Waldorf, Md. 20604-0156	FEB 28 '89	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024945 MAR -5 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05727 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
VINCENT	J.	BOULWARE	2	24	1989	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
MALE	BLACK	October 10, 1965	23 YRS.			2 24 1989	12:30 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Wash. D.C.	U.S.A.		Prince George's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Oxon Hill	front of 1559 South View Dr.	Construction	Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
Washington, D.C.		Washington		4738 Alabama Avenue, S.E.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Curtis		Boulware	Betty	Thomas	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	17a. ADDRESS
No	N/A	577-96-7407	Betty Boulware	4738 Alabama Ave.SE Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound to head

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ Head Only NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	11 PM 2-24- 1989	Self-inflicted.

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	front of	1559 South View Dr., Oxon Hill, MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Head Only, Inspection ☐, Inquiry ☐, and in my opinion Prince George's death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-25-89

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	March 4, 1989	Lincoln Memorial	Suitland, Maryland	
24a. FUNERAL DIRECTOR John T. Stewart, III	ADDRESS 4001 Benning Road, Stewart Funeral Home Washington, D.C.	25a. DATE REC'D. BY REGISTRAR MAR 01 '89	25b. REGISTRAR'S SIGNATURE Gisha Davidson-Randall	

07/84 25M BP DHMH 17 (VR A15 ME (5))

022136 FEB-9 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

REG. NO. 89 057223

1. DECEASED NAME (TYPE OR PRINT) FIRST: Juanita	MIDDLE: Marie	LAST: BOWLDING	2a. DATE OF DEATH MONTH DAY YEAR: February 1, 1989	2b. HOUR: 6:15 AM	
3. SEX: Female F	4. RACE: Black Black	5. DATE OF BIRTH MONTH DAY YEAR: DEC 18 1918	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON DC	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH: LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): DOCTORS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DOMESTIC	12b. KIND OF BUSINESS OR INDUSTRY: PRIVATE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: WASH DC	13b. COUNTY	13c. CITY OR TOWN: WASHINGTON	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS: 2020 19th PL SE	
14. FATHER'S NAME FIRST: LUTHER	MIDDLE	LAST: POPE	15. MOTHER'S MAIDEN NAME FIRST: GRACE	MIDDLE	LAST: WILSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218 30 4570	17. INFORMANT ADDRESS: GRACE HILL-DAUGHTER 5343 CHILLUM PL NE, DC		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiorgan failor
DUE TO, OR AS A CONSEQUENCE OF (b): A.R.D.S- Renal Failor
DUE TO, OR AS A CONSEQUENCE OF (c): Ruptured Right Iliac aneurysm.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: 1-24-89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ruptured aneurysm	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bahram Erham	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-2-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): BAHRAM ERHAM	22e. ADDRESS: 6510 KENILWORTH AVE SUITE 2500 RIVERDALE MARYLAND 20737		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/4/89	23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEMORIAL	23d. LOCATION CITY OR TOWN: LANDOVER COUNTY: MARYLAND STATE
24. FUNERAL DIRECTOR NAME / ADDRESS: ALEXANDER S POPE 2617 PA AVE SE WASH DC	25a. DATE REC'D. BY REGISTRAR: JAN 07 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR FEB 16 89

REG. NO. 89 057229

022917

1. DECEASED NAME (TYPE OR PRINT): First Betty; Middle Hunt; Last Bowman

2a. DATE OF DEATH KNOWN ☑ / ESTIMATED ☐: Month 2 Day 5 Year 89

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Month 03 Day 11 Year 98

6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.
IF UNDER 1 YR. Months / Days
IF UNDER 24 HRS. Hours / Min

2c. DATE PRONOUNCED DEAD: Month 2 Day 5 Year 89

2d. HOUR: 1902 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Nebraska

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Lanham

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Doctors Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Estate Manager

12b. KIND OF BUSINESS OR INDUSTRY: US Air Force

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: PG

13c. CITY OR TOWN: Seabrook

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 6808 96th Place 20706

14. FATHER'S NAME: First Ernest; Middle Bassett; Last Quible

15. MOTHER'S MAIDEN NAME: First Mary; Middle Eleanor; Last Hunt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 560-05-6831

17. INFORMANT: Norman Quible
ADDRESS: 6808 96th Place, Seabrook, MD 20706

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia due to cerebro-cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER

DATE SIGNED: 2-6-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 02/06/89

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Alexandria, Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS: Francis Gasch's Sons Funeral HOme, PA
4739 Baltimore Ave., Hyattsville, MD 20781

25a. DATE REC'D. BY REGISTRAR: FEB 9 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

022998 FEB 16 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05730
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Margie	Mae	Bowman	February 2, 1989	5:30p M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	White	May 17 1909	79 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Prince George MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Laurel	7511 Brooklyn Bridge Road 20707	Cashier	Shoe Store		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Laurel	YES ☐ NO ☒	7511 Brooklyn Bridge Rd 20707

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	Pinkney	Merson	Mary	May	Merson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		219-16-1253	Ann LePore	same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Severe emphysema

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
N/A

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
N/A		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 11/3, 19 88, to Present, 19 ____, that (I) (we) last saw the deceased alive on 1/26, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
L. CASAS	8317 CHERRY LA. LAUREL MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb 6, 1989	Union Cemetery	Burtonsville Md

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donaldson Funeral Home P.A. Laurel, Maryland	FEB 9 '89	Julia Davidson-Randall

10

DHMH-16 60M 1/73
(VR A 15 (4))

022419 FEB 13 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05731 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ELEANOR — MIDDLE: E. — LAST: BOYD

2a. DATE OF DEATH — MONTH DAY YEAR: February 6, 1989 — 2b. HOUR: 12:30A M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH — MONTH DAY YEAR: 11 10 26

6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Oxon Hill

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 7424 Dominion Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dry Cleaner

12b. KIND OF BUSINESS OR INDUSTRY: Private

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: PG

13c. CITY OR TOWN: District Hgts

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 1890 Addison Rd. South 20747

14. FATHER'S NAME — FIRST: Robert — MIDDLE — LAST: Blue

15. MOTHER'S MAIDEN NAME — FIRST: Geneva — MIDDLE — LAST: Rector

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 579-34-9241

17. INFORMANT — ADDRESS: Elizabeth Gray/7424 Dominion DR. Oxon Hill, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): inanition — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): metastatic lung cancer

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 24 19 89 to Feb 6 19 89, that (I) (we) last saw the deceased alive on Jan 24 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): D.J. HAIDAK MD

22e. ADDRESS: Clinton MD 8926 Woodyard Rd #201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 10, 89

23c. NAME OF CEMETERY OR CREMATORY: Washington National

23d. LOCATION — CITY OR TOWN: Suitland — COUNTY: PG — STATE: MD

24. FUNERAL DIRECTOR — NAME AND ADDRESS: JB Jenkins FH/7474 Landover Rd. Landover, MD

25a. DATE REC'D. BY REGISTRAR: FEB 08 1989

25b. REGISTRAR'S SIGNATURE: [signature]

Family Contacted Dr Agusto Rodriguez on 2/6/89 at 12:30am Medical Examiner

024073 FEB 23 89

1a FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05732 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ANNA MIDDLE:	LAST: Branch	2a. DATE OF DEATH MONTH DAY YEAR: 2-6-89	2b. HOUR: 0021 M		
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 1 25 10	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ~~PG~~ Montgomery Co MD.		
10. CITY OR TOWN OF DEATH: Takoma Park, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Food Service	12b. KIND OF BUSINESS OR INDUSTRY: Public Schools		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
District of Columbia		Washington	YES ☒ NO ☐	5007 13th Place, N.E.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Amos Darden	Ada Horn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT**	**ADDRESS**
no	578 34 0345	Ella Gilbert-daughter-32	Tuckerman

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	End Stage Renal Disease	4 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Hyperkalemia	1 Week
DUE TO, OR AS A CONSEQUENCE OF (c)	Cardiomyopathy	6 Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Stroke, Hypertension, Anemia,

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-3 19 89, to 2-5 19 89, that (I) (we) last saw the deceased alive on 2-5 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
Oki Kwon	M.D.		2/6/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	**22e. ADDRESS**		
Oki Kwon, M.D.	8580 Second Ave, Silver Spring MD 20910		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 11 1989	Washington National Ceme.	Suitland, Md.
24. FUNERAL DIRECTOR NAME / ADDRESS	**25a. DATE REC'D. BY REGISTRAR**	**25b. REGISTRAR'S SIGNATURE**	
Stewart Funeral Home-4001 Benning Road,	FEB 15'89	Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of twice.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 5

DHMH-1650M 1/81 (VRA 15, 4)

B24981 MAR 3 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057325 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CARL MIDDLE: Thomas LAST: BREECE			2a. DATE OF DEATH MONTH: 02 DAY: 13 YEAR: 89	2b. HOUR: 00:20 M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 12 DAY: 31 YEAR: 23	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.	
10. CITY OR TOWN OF DEATH: RIVERDALE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): LELAND MEM.HOS.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY: Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	P.G.	HYATTSVILLE	YES [X] NO [ ]	4104 CRITTENDEN ST. 20781

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Horace D. Breece	Delia Morgan	Yes-Navy / W.W.II	240-22-6093	(Wife) 4104 Crittenden Street Leora R. Breece Hyattsville, Md. 20781

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Respiratory failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hypercalcemia

DUE TO, OR AS A CONSEQUENCE OF (c): Pulmonary Neoplasm

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1985, 19____, to August, 19____, that (I) (we) last saw the deceased alive on 2/12/89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Norton Elson MD — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): NORTON ELSON — 22e. ADDRESS: 6525 Belcrest Rd Hyattsville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/15/89	Fort Lincoln Cemetery	Brentwood P.G. Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781	FEB 17 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 VA BP

DHMH - 1650M 1/81 (VRA 15, 4)

item 6,16b, film G649
3-9-89 I.J.

D23299 FEB 21 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 057 3-4

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Janet	H.	BREWER	02 09 89	10 10 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	Caucasian	11 29 1926	~~63~~ 62 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Kentucky	U.S.A.		PRINCE GEORGES COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CLINTON	SOUTHERN MARYLAND HOSPITAL	Homemaker	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	P. G.	Forestville	YES ☐ NO XX	4013 Suit Rd. 20747

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	L.	Harrell	Pearl		Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	402-30-3907	Thomas R. Brewer	Same as 13 A-E

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory Arrest	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Respiratory Insufficiency	2-3 Days
DUE TO, OR AS A CONSEQUENCE OF (c)	Complications of Breast Excision	4 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 1/1, 19 89, to 2/9, 19 89, that (I) (we) last saw the deceased alive on 2/9, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C. COLAO, MD	3710 RIVIERA STREET, MARLOW Hgt. MD 20748

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	02/14/89	Maryland Veterans Cem	Cheltenham	Prince Geo.	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc.	6633 Old Alexander Ferry Rd Clinton, Md 20735	FEB 16 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

024194 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05735
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Clara CLARA	MIDDLE: T.	LAST: Bridgett BRIDGETT	2a. DATE OF DEATH MONTH: 2	DAY: 22	YEAR: 89
2b. HOUR	2.25 PM M					
3. SEX	Female FEMALE	4. RACE	Caucasian	5. DATE OF BIRTH MONTH: 2	DAY: 05	YEAR: 99
6. AGE (IN YEARS LAST BIRTHDAY)	89 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George's MD.
10. CITY OR TOWN OF DEATH	Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P. G.	Brandywine	YES ☐ NO ☒	15118 Nelson Perrie Rd 20613

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James		Caywood	Edna	D.	Lucas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	578-09-0019D	Larry Carter	Same as 13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF (b) LEFT VENTRICULAR FAILURE

DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCTION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Coronary artery disease.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
—	—	YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/21/89 19 ____, to 2/22/89 19 89, that (I) (~~was~~) last saw the deceased alive on 2/21/89 19 ____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE DEGREE: Smithe for DR G.S. RATH ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR G.S. RATH. — 22e. ADDRESS: Charles Fox Center, Waldorf, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/25/89	Cedar Hill Cemetery	Suitland Prince George's Md.

24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc. ADDRESS: 6638 Old Alexander Ferry Rd Clinton, Md 20735

25a. DATE REC'D. BY REGISTRAR: FEB 23 1989 — 25b. REGISTRAR'S SIGNATURE: Tricia Davidson-Randall

BP 2

DHMH - 1650M 1/81 (VRA 15, 4)

024130 FEB 29 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05736 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS AUTHORITY TO TRANSPORT AND TO OBTAIN A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Samuel	Eugene	Briscoe	2-	8-	1989	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	Black	12-14-59	29 YRS.			2- 8- 1989	5:55A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.	U.S.A.		Prince Georges County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly	Prince Georges General Hospital	Auto Mechanic					

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	St. Mary's	Lexington Pk.	YES X NO ☐	501 Donaldson St. 20653

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Clarence		Briscoe	Doris		Courtney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	-	220-80-6207	Doris Ratchford	20653 Lexington Pk., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound to head

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		HEAD ONLY YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] MD TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-9-89

VC EXAMINER'S NAME (TYPE OR PRINT) James Kaplan, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/13/89	True Holiness Church	Park Hall-St.Marys, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leroy E. Berry-Huntingtown, Md. 20639	FEB 13 1989	Julia Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023344 FEB-27-89

REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 057737

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST		2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR		
	LLOYD	C	BROADWATER	JR.	XX ☐	2-	6-	19 89		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	White	12-27-1953	35 YRS.						2-	6-	19 89	4:23 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
WV	USA		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Laurel	Greater Laurel/Beltsville Hospital	operating engineer	plumbing & heating

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Prince George	Laurel	YES ☒ NO ☐	1 N. Zona Street 20707 Parkway Villa

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Lloyd C. Broadwater, Sr.	Martha Rounds		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		213-64-7713	Mrs. Brenda A. Broadwater, Laurel, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-6-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	02-09-1989	Restlawn Memorial Park	LaVale Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, MD 21502		FEB 08 1989	Gina Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 7

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05738
REG. NO.

02499-5 MAR-8 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Mary	L.	Brougher	February 17, 1989	7:30P. M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS: HOURS MIN.
Female	Caucasian	Sept. 4 1905	83 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Missouri	U.S.A.		Prince George's MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Ft. Washington	Ft. Washington Rehabilitation Center	Teacher	Mo. Schools		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Prince George	Ft. Washington	YES ☐ NO ☒	11908 Bion Drive	20744

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	Hayden	Morrison	Laura	Ann	Rinker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		499-50-5915	John Brougher	11908 Bion Drive Ft. Washington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 years

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from Nov 19 83 to 2/17 19 89, that (I) (we) last saw the deceased alive on Jan 30 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert M. Nedzbala, M.D.	11701 Livingston Rd. Ft. Washington, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/21/89	Maple Park Cemetery	Aurora Lawrence Missouri

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George P. Kalas Funeral Home	6160 Oxon Hill Rd Oxon Hill, Md.	FEB 21 '89	Lisha Davidson-Randall

(25)

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024949 MAR 1 7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005739
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Camille MIDDLE Mackland LAST Brown

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 21 YEAR 19 89 — 2b. HOUR M

3. SEX: Female — 4. RACE: Black — 5. DATE OF BIRTH: MONTH 1 DAY 16 YEAR 15 — 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 21 YEAR 19 89 — 2d. HOUR 1:50 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): St. Louis Missouri — 7b. CITIZEN OF WHAT COUNTRY? United States — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD

10. CITY OR TOWN OF DEATH: Capitol Heights — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6970 Walkermill Road # A-2 — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Shipping Insp. — 12b. KIND OF BUSINESS OR INDUSTRY: Government

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: Prince Georges — 13c. CITY OR TOWN: Capitol Heights — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 6970 Walkermill Rd. # A2

14. FATHER'S NAME: FIRST Frank MIDDLE LAST Mackland — 15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST Nasbitt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 494-01-6921 — 17. INFORMANT: Calbin Brown — ADDRESS: 6970 walkermill Rd. # A2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriopulmonic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Vascular bypass - legs 15 years

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Romero — M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-21-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Romero MD — ADDRESS: 507 Raynham Ct. Co Springs, Md 30748

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 3-2-89 — 23c. NAME OF CEMETERY OR CREMATORY: Washington Park — 23d. LOCATION CITY OR TOWN: Berkley — COUNTY: — STATE: Missouri

24. FUNERAL DIRECTOR NAME AND ADDRESS: Comer & Hodges 4901 Marlboro Pk. Coral Hills, Md

25a. DATE REC'D. BY REGISTRAR: FEB 28 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

022470 FEB 13 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005740

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	KNOWN XX / ESTIMATED ☐	MONTH	DAY	YEAR	2b. HOUR		
	Jeffrey	L.	Brown			2-	1-	19 89		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	Caucasian	6-18-61	27 YRS.						2-	1-	19 89	3:00P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Massachusetts	U.S.A.		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cheverly	Prince Georges General Hospital	Electronics Engineer	Microwave Communications

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince George	Adelphi	YES X NO ☐	2014 Ouebec Street 20783

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Stephen	K.	Brown	Susan		Ireland

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		216-90-1660	Susan Brown	Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cranio-cervical trauma

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

8120

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	7:20PM 1-28-89	Driver in auto/auto collision

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	road	Kenilworth Avenue	/Benning Road,NE Washington,DC		

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-2-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	2-5-89	Metropolitan	Alexandria	Fairfax	Virginia

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall Evans Funeral Home,P.A.	16000 Annapolis Road Bowie, Maryland	FEB 09 1989	Julia Dawson-Lindsay

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 4 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

24999 MAR -8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05741
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
Willie	Bunyon	BROWN	February 12, 1989	6:40P M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	
MALE	BLACK	May 27, 1906	86 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH			
South Carolina	U.S.A.		Prince Georges MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
Lanham	Doctor's Hospital	Retired	Private			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
District of Columbia		Washington	YES [X] NO [ ]	641 Elliott St., N.E.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Bunyon		Brown	Anna		(Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	579-03-9245	David Brown	12407 Ranson Drive Glendale, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease — 4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary heart disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK	NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
[ ]	[ ]					

22a. I certify that ~~I~~ (this hospital) attended the deceased from 2/26, 19 88, to 2/12, 19 89, that ~~I~~ (we) last saw the deceased alive on 2/12, 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Frederick H Wilhelm	M.D.	ATTENDING PHYSICIAN [ ]	MEDICAL DIRECTOR [ ]	STAFF PHYSICIAN [X] 2/12/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Frederick H. Wilhelm M.D.	5807 Annapolis Road Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	February 17, 1989	Harmony Memorial	Landover,	Maryland	

24a. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gerald T. Stewart, III	4001 Benning Road, N.E. Stewart Funeral Home Wash. D.C.	FEB 21 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH 16 50M 1/81 (VRA 15, 4)

024956 MAR-8 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05742 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Clinton	Hatcher	BRYANT	February 24, 1989	2:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasion	09 28 05	83 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, DC	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Prince George's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	AMI Doctors' Hospital of PG County	Field Supervisor	Dist. Highway

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	PG	Hyattsville	YES ☒ NO ☐	6945 Emerson Street 20784

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ruben	Alexander	Bryant	Flemintine	Hilda	Hughes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	220-44-0786	Dorothy H. Barton	9516 Wire Avenue Silver Spring, MD 20901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma Vocal Lungs — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

Metastatic Carcinoma to Vocal Cords

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~the hospital~~) attended the deceased from Sept 20 1988 to 2/24/89 1989, that (I) (~~was~~) last saw the deceased alive on 2/24/89 and that in (my) (~~the~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Thomas G. McCann	MD	☐ / ☒ / ☐	2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/27/89	Md. Nat'l Mem. Park	Laurel PG Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, PA	4739 Baltimore Ave., Hyattsville, MD 20781	FEB 28 89	Gina Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VSA - 15, 4)

(12) IVA

025077 MAR-9 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05743
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY MIDDLE: L. LAST: BUCKINGHAM				2a. DATE OF DEATH MONTH DAY YEAR: 02/22/89	2b. HOUR: 00:12 M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 05/05/18	6. AGE (IN YEARS LAST BIRTHDAY): 101 YRS	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.		
10. CITY OR TOWN OF DEATH: RIVERDALE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): LELAND MEM. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	P.G.	Oxon Hill	YES ☒ NO ☐	1515 Fergerson Lane 20745

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
FIRST: Unknown MIDDLE: LAST: Havner	FIRST: Maude MIDDLE: LAST: Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 579 14 9513	17. INFORMANT: Frederick MD ADDRESS: 20678 Howard Heinbuch/1725 Kingswood Dr/Prince	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c): Pneumonia, LR.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): UTI.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/21/89 19__, to X 19__, that (I) (we) last saw the deceased alive on 2/21/89 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2/22/89.

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
YEAR KWON H. YOON	7307 Baltimore Ave #111 College Park Md 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb/25/89	Washington National	Suitland PG MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert E Wilhelm Funeral Home Suitland MD	FEB 23 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025095 MAR - 9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05744
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Daisy MIDDLE Ann LAST Burch.

2a. DATE OF DEATH: MONTH 2 DAY 21 YEAR 89

2b. HOUR: 1 P M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH: MONTH Aug. DAY 14 YEAR 1909

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES CO, MD.

10. CITY OR TOWN OF DEATH: CLINTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: ,Maryland

13b. COUNTY: Prince George's

13c. CITY OR TOWN: Fort Washington

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 8312 Bock Road 20744

14. FATHER'S NAME: FIRST Lorenzie MIDDLE Proctor LAST

15. MOTHER'S MAIDEN NAME: FIRST Lilly MIDDLE LAST Bulter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 579 36 5820

17. INFORMANT: Son Steve Burch ADDRESS: 10602 Barnsdale Drive Cheltenham, Md. 20623

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute lateral myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/19 19 89 to 2-21 19 89, that (I) (we) last saw the deceased alive on 2-21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John Patterson MD. DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John C. Patterson, MD

22e. ADDRESS: 7501 Surratts Rd. #201 Clinton Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-25-89

23c. NAME OF CEMETERY OR CREMATORY: St. Ignatius Cemetery

23d. LOCATION CITY OR TOWN: Oxon Hill COUNTY: Prince George's STATE

24. FUNERAL DIRECTOR NAME: Huntt Funeral Home, Inc. ADDRESS: P.O. Box 156 Waldorf Md. 20604

25a. DATE REC'D. BY REGISTRAR: FEB 27 '89

25b. REGISTRAR'S SIGNATURE: Md. Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 50M 1/81 (VRA 15, 4)

024950 MAR 1 8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05745
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Sadie	MIDDLE: A.lberta	LAST: Burch	
2a. DATE OF DEATH MONTH DAY YEAR: February 18, 1989	2b. HOUR: 7:20 PM		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 7 - 13 - 89	6. AGE (IN YEARS LAST BIRTHDAY): 99 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.
10. CITY OR TOWN OF DEATH: Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Home, Inc.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerical	12b. KIND OF BUSINESS OR INDUSTRY: U.S.Government
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Wash D.C.	13b. COUNTY: ----------	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 1902 S Street S E 20020			
14. FATHER'S NAME FIRST MIDDLE LAST: James Mattingly	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Margaret Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 579-60-4125	17. INFORMANT ADDRESS: Jo Anne Heberle Rt. #2, Box 606 E White Plains, Md. 20695

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Respiratory Infection, Terminal — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF (b): Intermittent and Recurrent Urinary Tract Infection — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerosis, Senile Cerebral Atherosclerosis, Anemia, Advanced Age

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) ~~(the hospital)~~ attended the deceased from ~~1975 July~~ Feb 17 1989 to Feb 18 1989, that (I) ~~(we)~~ last saw the deceased alive on Feb 17 1989, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: John F. Brennan Jr M.D	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: Feb-18-1989
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN F. BRENNAN, JR, M.D	22e. ADDRESS: 3415 HAMILTON ST. HYATTSVILLE, MD 20872		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb.21,1989	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE: Suitland, P.G., Maryland
24. FUNERAL DIRECTOR NAME: Huntt Funeral Home	ADDRESS: P.O. BOX 156 WALDORF, MD. 20604	DATE REC'D. BY REGISTRAR: FEB 28 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

022987 FEB 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 05746
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First Richard Middle Percival Last Burgee
Richard Burgee

2a. DATE OF DEATH: Month Feb. Day 2 Year '89
2b. HOUR: 2:29 PM

3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: Month September Day 9, Year 1898
6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS
If UNDER 1 YEAR: MONTHS / DAYS
If UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Riverdale
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Printing Office
12b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Prince Geo.
13c. CITY OR TOWN: Hyattsville
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 3900 Hamilton Street #B101

14. FATHER'S NAME: First Edward Middle Emanuel Last Burgee
15. MOTHER'S MAIDEN NAME: First Sara Middle Elizabeth Last Eckloff

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes
(IF YES, GIVE WAR OR DATES): WW I
16b. SOCIAL SECURITY NO.: 220-44-7245
17. INFORMANT: Zela O. Burgee
ADDRESS: 3900 Hamilton St.#B101 Hyattsville,Md. 20781

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c): atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from July, 1988, to 2/2/, 1989, that (I) (we) last saw the deceased alive on 2/1, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABRAHAM B. DABECA
22e. ADDRESS: 4404 Queens Chapel Rd. Riverdale

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal
23b. DATE: Feb.4,1989
23c. NAME OF CEMETERY OR CREMATORY: George Washington
23d. LOCATION (CITY OR TOWN): Medical School (COUNTY): Wash.DC.

24. FUNERAL DIRECTOR (NAME): Columbia Mortuary Services
(ADDRESS): 225 Missouri Ave. N.W. Washington D.C. 20011
25a. DATE REC'D. BY REGISTRAR: FEB 6 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DHMH - 16 50M 1/81 (VRA 15, 4)

024984 MAR-3 100 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05747 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Richard	Leroy	Burket, Sr.	2	14	89 / 10:15 AM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) / IF UNDER 1 YEAR MONTHS / DAYS / IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	9	3	30	58 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Clinton	Pineview Manor Ext Care Center	Salesman	Automobile

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE
Maryland	Pr. George's	Temple Hills		5204 Springwood Drive 20748

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Ernest		Burket	Florence / Lohr

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	unavailble	214-30-2347	Richard L. Burket, Jr.	4614 Goldeneye Place Waldorf, Md. 20603

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
Congestive Heart failure.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-17 19 87 to 2-14 19 89 that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
M. Montaan		2/14/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	
M. Montaan	4235 28th Avenue Temple Hills, Md. 20748	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-17-89	Ft. Lincoln Cemetery	Brentwood, Pr. George's, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781	FEB 17 '89	Julia Davidson-Randall	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

(3)

IVA BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Item 13 per P.G. Co.

1 - STATE REGISTRAR 3/14/89 DHMH

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005748
REG. NO.

025 740 MAR 14 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Emma — MIDDLE: P — LAST: Burrell

2a. DATE OF DEATH — KNOWN ☑ / ESTIMATED ☐ — MONTH 2 DAY 26 YEAR 1989 — 2b. HOUR M

3. SEX: Female — 4. RACE: Negro — 5. DATE OF BIRTH: MONTH 9 DAY Aug YEAR 1905 — 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 26 YEAR 1989 — 2d. HOUR 7:20 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX ☑ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George MD.

10. CITY OR TOWN OF DEATH: MD — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 16104 Pointer Ridge Bowie — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Minister — 12b. KIND OF BUSINESS OR INDUSTRY: None

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: PG — 13c. CITY OR TOWN: BOWIE — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 16104 Pointer Ridge DR 20716

14. FATHER'S NAME — FIRST: William — MIDDLE: G — LAST: Simms

15. MOTHER'S MAIDEN NAME — FIRST: Florence — MIDDLE: Pinkney — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): b No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 216-44-5267

17. INFORMANT: Estrellita Joyner — ADDRESS: 3906 Callaway Ave Baltimore Md, 21215

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular disease — DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-27-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez MD — ADDRESS: 3509 Raytown Ct. Co Springs Md 20748

23a. BURIAL, CREMATION, REMOVAL (RECORD): BURIAL — 23b. DATE: 3/2/89 — 23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem — 23d. LOCATION CITY OR TOWN: Suitland — COUNTY: P.G — STATE: MD

24. FUNERAL DIRECTOR (NAME): John T Ritner — ADDRESS: 3515 12th St. NE DC 20017 — 25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Knisley Register

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM 344. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023316 FEB 2 | 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057499 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: EUGENIA	MIDDLE: M.	LAST: BYRNE	2a. DATE OF DEATH MONTH: 02 DAY: 9 YEAR: 89	2b. HOUR: 216 A M	
3. SEX: Female	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: August DAY: 28, YEAR: 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mexico	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Carroll Manor	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: None	13b. COUNTY: None	13c. CITY OR TOWN: Wash. D.C.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 4619 48th Street, N.W. (20016)	
14. FATHER'S NAME FIRST: Millard	MIDDLE: F.	LAST: Mitchell	15. MOTHER'S MAIDEN NAME FIRST: Elizabeth	MIDDLE: --	LAST: Fleming
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 577 48 8663	17. INFORMANT: Son Francis A. Byrne Jr.	ADDRESS: Same as #13 above.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MASSIVE LEFT CORTICAL STROKE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): ATHEROSCLEROTIC CARDIORENAL VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SEVERE CONGESTIVE HEART FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from FEBRUARY 6, 19 89, to FEBRUARY 9, 19 89, that (I) (~~we~~) last saw the deceased alive on FEBRUARY 8 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Marta Anne Schneider MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTA ANNE SCHNEIDER MD	22e. ADDRESS: 5401 MACARTHUR BLVD NW WASH DC 20016	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: Feb. 13, 1989	23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington Va.	
24. FUNERAL DIRECTOR NAME: Robert A. DeVol	ADDRESS: D Vol Funeral Home/2222 Wisc. Washington D.C.	25a. DATE REC'D. BY REGISTRAR: FEB 16 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024293 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05750
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MANUEL	MIDDLE: A.	LAST: CABANILLAS	2a. DATE OF DEATH MONTH DAY YEAR: February 23, 1989	2b. HOUR: 3:10 A M	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Apr. 3, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.		
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctors Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Manager	12b. KIND OF BUSINESS OR INDUSTRY: DOD U.S. Govt.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Bowie	YES ☒ NO ☐	2205 Hallow Lane/ 20716

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Peter	John	Cabanillas	Liva	M.	Martinez

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		059-03-4775	John D. Cabanillas	5 Farragut Street Portsmouth, VA 23702

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral hemorrage

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): chronic obstructive pulmonary disease.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/18, 19 89, to 2/23, 19 89, that (I) (we) last saw the deceased alive on 2/23, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Andrew Dabin MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Andrew Dabin MD	3231 Superior Lane Bowie, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 25, 1989	Resurrection Cemetery	Clinton, P.G., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	MAR 1 - 1989	Julia Davidson-Vandegrift

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024450 MAR-2-89

FORM 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05751
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	ROSCOE H. CAREY	2a. DATE OF DEATH MONTH / DAY / YEAR	02 / 19 / 89	2b. HOUR	2:45 AM
3. SEX	Male	4. RACE	Black	5. DATE OF BIRTH MONTH / DAY / YEAR	06 / 15 / 1896
6. AGE (IN YEARS LAST BIRTHDAY)	92 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges Co. MD.
10. CITY OR TOWN OF DEATH	Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Greater Laurel Beltsville Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE)	Truck Driver
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	Pr. Geo	13c. CITY OR TOWN	Beltsville
13d. INSIDE CITY LIMITS? YES ☐ NO ☐		13e. STREET ADDRESS	12324 Conway Rd.	ZIP CODE	20705
14. FATHER'S NAME FIRST / MIDDLE / LAST	JESSIE CAREY	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Mollie HOLLAND		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	210-38-3722	17. INFORMANT ADDRESS	William Carey (SON) 610 10th St. Laurel, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SENILE COPD ; CHRONIC COR PULMONALE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-17-89 to 2-19-89, that (I) (we) last saw the deceased alive on 2-18-89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Delima MD	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-19-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	CHRISTNE DELIMA MD	22e. ADDRESS	14201 LAUREL PK DRIVE #116 LAUREL MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2-23-89	Md Nat'l Mem. Park	Laurel, Pr. Geo., MD	
24. FUNERAL DIRECTOR (NAME)	George R. Snowden	Rockville, MD 20850	25a. DATE REC'D. BY REGISTRAR: FEB 27 1989	25b. REGISTRAR'S SIGNATURE

022971 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05752
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	JOSEPH	MIDDLE M.	LAST CARRICK	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR 6.40P M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	July 24, 1913	75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		PRINCE GEORGES MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER		Technician	Printing Co.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Pr. George's	Seat Pleasant	YES ☒ NO ☐	6004 Addison Road 20743

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Cassius E. Carrick	Frances R. Loveless

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-------	579-07-2888	Irene V. Carrick same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Malignant Lymphoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO, OR AS A CONSEQUENCE OF (b) Pleural effusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from August, 1988, to 2/7, 1989, that (I) (we) last saw the deceased alive on 2/7, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Harvey J. Kaizer	MD		2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
HARVEY J. KAIZER	8926 Lewisdale Rd Clinton MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-10-89	Cedar Hill Cemetery	Suitland, Prince George's, Md

24. FUNERAL DIRECTOR (NAME / ADDRESS)	25. DATE RECD. BY REGISTRAR	25a. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781	FEB 89	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

024952 MAR-8

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05753
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows other conditions, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — First: Myrtle; Middle: A.; Last: Carter				2a. DATE OF DEATH — Month: Feb.; Day: 19; Year: 1989	2b. HOUR: 7:25 AM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH — Month: 6; Day: 1; Year: -1895	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS.	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N. Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION: Southern Maryland Hospital Ctr	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Charles	Waldorf	YES ☐ NO ☒	2604 Ferguson Ct. 20604

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
First: William; Middle: ; Last: Albright	First: Emma; Middle: ; Last: Wilson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT
No	- - -	225-01-0221	Joyce M. Stover

ADDRESS: 3157 Huntington Cir. Waldorf, Md. 20602

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIO RESPIRATORY ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	RESPIRATORY DISTRESS	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ASCVD ANEMIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/6/89 to 2/19/89, that (I) (we) last saw the deceased alive on 2/17/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Annette C. Gonsalves	5 Post Office Rd Waldorf, Md. 20604

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN, COUNTY, STATE
Burial	2-22-89	Mt. View Cemetery	Danville, Pittsylvania Va.

24. FUNERAL DIRECTOR — NAME, ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home P.O. Box 156 Waldorf, Md. 20604	FEB 28 '89	Julia Davidson-Randall

(15) BP

DHMH - 16 50M 1/81 (VRA 15, 4)

022319 FEB 1989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

89 REG. NO. 05754

1. DECEASED NAME (TYPE OR PRINT) FIRST: Frank	MIDDLE: E.	LAST: Cerceo				2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH: 2- DAY: 4- YEAR: 1989	2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 27 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-6-1989	2d. HOUR: 2:24P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒				9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.	
10. CITY OR TOWN OF DEATH: Beltsville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11902 Beltsville Drive					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Bricklayer	12b. KIND OF BUSINESS OR INDUSTRY: construction
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. Georges	13c. CITY OR TOWN: Beltsville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐			13e. STREET ADDRESS: 11902 Beltsville Dr 20705	
14. FATHER'S NAME FIRST: Joseph	MIDDLE:	LAST: Cerceo				15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE:	LAST: Yaselli
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 579-03-3283				17. INFORMANT: Josephine Grove-sister-Edgewater, Md. 2103	ADDRESS: P.O. Box 307

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Emphysema and Hypertensive arteriosclerotic cardiovascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE M.D. Julia Davidson-Randall TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-7-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-9-1989	Gate of Heaven	Silver Spring Montgomery Md.

24 FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/ Rinaldi Funeral Home 11800 N.H. Ave., Sil. Spr. Md. 20904	FEB 09 1989	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024191 FEB 23 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005755

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
FRANCIS	M	CERRITO	FEBRUARY 22, 1989	1:55P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	NOVEMBER 5, 1927	61 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		PRINCE GEORGE"S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CLINTON	PARKWOOD HOSPITAL	Realtor (Cerrito)	Self-employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	P. G.	Clinton	YES [ ] NO [XX]	9211 Piscataway Rd. 20735

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Anthony		Cerrito	Mary		DeMarca

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	205-18-8370	Joan R. Cerrito	Same as 13 A-E

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 2/21 19 89 to 2/22 19 89, that (I) ~~(we)~~ last saw the deceased alive on 2/21 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	2/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
FRANK M. RYAN, M.D.	9401 INDIAN HEAD HWY, #135 FT. WASHINGTON, MD 20744

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/25/89	Resurrection Cemetery	Clinton Prince George's Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735	FEB 23 1989	Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other than natural cause, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

024512 MAR

Item#18a,22a per mfd Film6493.27/890g

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005756

1. DECEASED NAME (TYPE OR PRINT): FIRST Samuel; MIDDLE; LAST Chaney

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH 2 DAY 10 YEAR 1989 — 2b. HOUR

3. SEX: MALE — 4. RACE: BLACK — 5. DATE OF BIRTH: MONTH 4 DAY 29 YEAR 67 — 6. AGE (IN YEARS LAST BIRTHDAY): 1 YRS. — IF UNDER 1 YR.: MONTHS 2, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 10 YEAR 1989 — 2d. HOUR 8:21 a.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON DC — 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES — 8. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County, MD.

10. CITY OR TOWN OF DEATH: Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George's General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NONE — 12b. KIND OF BUSINESS OR INDUSTRY: NONE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: PRINCE GEORGE — 13c. CITY OR TOWN: SEAT PLEASANT — 13d. INSIDE CITY LIMITS? YES X NO ☐ — 13e. STREET ADDRESS: 6000 JEFFERSON HGTS DR

14. FATHER'S NAME: FIRST SYLVESTER; MIDDLE; LAST CHANEY

15. MOTHER'S MAIDEN NAME: FIRST CHERYL; MIDDLE LYNN; LAST OLIVER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 217 21 5389

17. INFORMANT: SYLVESTER CHANEY — ADDRESS: FATHER 6000 JEFF HGTS DR

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John E. Smialek — M.D. — TITLE (SPECIFY): Chief MEDICAL EXAMINER — DATE SIGNED: 2-11-89

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. — ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 2/16/89 — 23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CE METERY — 23d. LOCATION CITY OR TOWN: SUITLAND COUNTY: PG STATE: MARYLAND

24. FUNERAL DIRECTOR NAME: ALEXANDER S POPE — ADDRESS: 2617 PA AVE SE WASH DC

25a. DATE REC'D. BY REGISTRAR: FEB 24 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 373 DHMH - 17 (VR A15 ME (5))

024985. MAR 13 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05757 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Audrey	MIDDLE: Elizabeth	LAST: Chase	2a. DATE OF DEATH MONTH DAY YEAR: 2/10/89		2b. HOUR: 1754 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 5, 1929	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George County MD.		
10. CITY OR TOWN OF DEATH: Clinton M.d.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Mt. Rainier	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS / ZIP CODE: 3352 Chillum Road, #102 20712	
14. FATHER'S NAME FIRST: Emil	MIDDLE	LAST: Larson	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: L.	LAST: Merritt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578-34-7615	17. INFORMANT (Husband) Robert G. Chase	ADDRESS: 3352 Chillum Rd. #102 Mt. Rainier, Md. 20712	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) BOWEL OBSTRUCTION — DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SCHIZOPHRENIA HYPOTHYROID, OBSTRUCTIVE PULMONARY DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 2/4, 19 89, to 2/10, 19 89, that I (we) last saw the deceased alive on 2/10, 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 2/11/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): P. WISOTSKY M.D. — 22e. ADDRESS: 6188 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/14/89	23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.	23d. LOCATION CITY OR TOWN: Arlington	COUNTY / STATE: Virginia
24. FUNERAL DIRECTOR NAME AND ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024316 FEB 29 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05753

1. DECEASED NAME (TYPE OR PRINT): FIRST Dennis MIDDLE O LAST Clayton

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 24 YEAR 1989 — 2b. HOUR M

3. SEX: Male — 4. RACE: Negro — 5. DATE OF BIRTH: MONTH 12 DAY 8 YEAR 35 — 6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS. — IF UNDER 1 YR.: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 24 YEAR 1989 — 2d. HOUR 6P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD

10. CITY OR TOWN OF DEATH: M — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Retired — 12b. KIND OF BUSINESS OR INDUSTRY: None

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: PG — 13c. CITY OR TOWN: Seat Pleasant — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 7000 Pleasant Valley Ct. 20743

14. FATHER'S NAME: FIRST Wendell MIDDLE H. LAST Clayton

15. MOTHER'S MAIDEN NAME: FIRST Julia MIDDLE Briggs LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 223440765 — 17. INFORMANT: Delores E. Clayton (Same as above) ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple pulmonis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): — DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. TITLE (SPECIFY) Dp. MEDICAL EXAMINER — DATE SIGNED 2-25-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez M.D. ADDRESS 309 Lawyers Ct. Gr. Mt. 20774

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE 3-2-89 — 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln — 23d. LOCATION CITY OR TOWN Brentwood COUNTY Md. STATE

24. FUNERAL DIRECTOR NAME: John L. Reams Co. ADDRESS — 25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023129 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05759 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): First Evans; Middle Hamilton; Last CLIPPER

2a. DATE OF DEATH: Month/Day/Year: February 7, 1989

2b. HOUR: 9:26P M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: Month Mar. Day 15, Year 1912

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County, MD.

10. CITY OR TOWN OF DEATH: Lanham

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctor's Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Manager

12b. KIND OF BUSINESS OR INDUSTRY: Drug Warehouse

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: P.G.

13c. CITY OR TOWN: Bowie

13d. INSIDE CITY LIMITS? YES XX NO [ ]

13e. STREET ADDRESS: 13116 Forest Drive/20715

14. FATHER'S NAME: First Hamilton; Middle; Last Clipper

15. MOTHER'S MAIDEN NAME: First May; Middle; Last A[illegible]

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-05-5273

17. INFORMANT: Bernard E. Clipper, ADDRESS: Rt. 3 Box 20 Salisbury, MD 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

(IMMEDIATE CAUSE (a)) CARDIAC ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. Martin MD DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]

22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JACKIE L. MARTIN

22e. ADDRESS: AMI Doctors Hospital, P.G County

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/11/89

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

23d. LOCATION: City or Town Annapolis, County Anne Arundel, State MD

24. FUNERAL DIRECTOR: Beall-Evans Funeral Home, P.A.

ADDRESS: 16000 Annapolis Rd. Bowie, MD 20715

25a. DATE REC'D. BY REGISTRAR: FEB 15 1989

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

24305 FEB 29 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05760 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: VELMA	MIDDLE	LAST: COCHRAN	2a. DATE OF DEATH MONTH: 02 DAY: 25 YEAR: 89	2b. HOUR: 10 31PM M	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: May 11, 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Housekeeping	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George's	13c. CITY OR TOWN: District Heights	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 1302 Fairfield Drive / 20747	
14. FATHER'S NAME FIRST: Aaron	MIDDLE: A.	LAST: Cochran	15. MOTHER'S MAIDEN NAME FIRST: Jennie	MIDDLE	LAST: Hunter
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 410-48-1984	17. INFORMANT ADDRESS: Louise Mack, Same as 13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/15/89 to 2/25/89, that (I) (we) last saw the deceased alive on 2/25/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-26-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Fayaz A. Shaikh 22e. ADDRESS: P.G. Hospital, Cheverly MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 3-4-89	23c. NAME OF CEMETERY OR CREMATORY: Galilee Cemetery	23d. LOCATION CITY OR TOWN: Germantown,	COUNTY / STATE: Tennessee
24. FUNERAL DIRECTOR NAME / ADDRESS: M. J. Edwards Funeral Home, 1165 Airways Blvd., Memphis, TN 38114		25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Item3's18a,b,22a per med Film G649 3/30/89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 05761

025241 MAR 14 89

DECEASED NAME (TYPE OR PRINT): LAWRENCE (FIRST) K. (MIDDLE) COLEMAN (LAST)

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 2 DAY 26 YEAR 89 — 2b. HOUR

3. SEX: Male — 4. RACE: Black — 5. DATE OF BIRTH: MONTH 1 DAY 30 YEAR 45 — 6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 26 YEAR 89 — 2d. HOUR 5:02 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Spartanburg, S.C. — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.

10. CITY OR TOWN OF DEATH: Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George's General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mail Carrier — 12b. KIND OF BUSINESS OR INDUSTRY: Unknown

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: PG — 13c. CITY OR TOWN: Forestville — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 8510 Bonny Drive 9999

14. FATHER'S NAME (FIRST) William (MIDDLE) (LAST) Coleman

15. MOTHER'S MAIDEN NAME (FIRST) Mildred (MIDDLE) (LAST) Means

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-58-8689

17. INFORMANT ADDRESS: Mrs. Emelda Coleman/wife/same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Fatty liver

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic alcohol abuse

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ],

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED 2-26-89

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. — ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 3/3/89 — 23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial — 23d. LOCATION CITY OR TOWN: Suitland, COUNTY: Md. STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: John T. Rhines Co., 3015 12th St. N.E., D.C. 20017

25a. DATE REC'D. BY REGISTRAR: MAR 10 1989 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP405 DHMH - 17 (VR A15 ME (5))

024916 MAR -8

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05762
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
LURLINE		COLTER	02-06-89	12 30PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
FEMALE	BLACK	March 1, 1934	54 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	
South Carolina	U.S.A		PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	School Bus Driver, P.G. Co	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	Prince Georges	Capitol Heights	YES ☐ NO X	1111 Eastern Avenue 20743

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Sam		Sistrunk	Pearline		Fields

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	220-38-4597	James Colter	1111 Eastern Avenue Capitol Heights, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent Pulmonary embolism

DUE TO, OR AS A CONSEQUENCE OF (c) Severe cardiomyopathy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Congestive Heart Failure · Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/31, 19 89, to 2-6, 19 89, that (I) (we) last saw the deceased alive on 2-5 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Villamor S. Reyes	M.D.	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
VILLAMOR S. REYES, M.D.	6501 Landover Rd. Cheverly, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 11, 1989	Ft. Lincoln Cem.	Brentwood, Maryland

TYPED NAME OF FUNERAL DIRECTOR OR AUTHORIZED AGENT	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Thomas T. Stewart, III Stewart Funeral Home	4001 Benning Road, N.E. Washington, D.C.	FEB 10 '89	Julia Davidson-Randell

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025281 MAR 14 89

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 057633

1. DECEASED NAME (TYPE OR PRINT): FIRST Raymond MIDDLE James LAST Connolly

2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 15 YEAR 1989 — 2b. HOUR M

3. SEX: Male — 4. RACE: WHITE — 5. DATE OF BIRTH MONTH DAY YEAR: MARCH 4 1910 — 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH 2 DAY 15 YEAR 1989 — 2d. HOUR 1:30 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.

10. CITY OR TOWN OF DEATH: LANHAM — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): DOCTORS HOSPITAL — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CONTRACTING OFFICER — 12b. KIND OF BUSINESS OR INDUSTRY: STATE DEPT

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: PR GEORGES — 13c. CITY OR TOWN: GREENBELT — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 35C RIDGE ROAD 20770

14. FATHER'S NAME FIRST JOHN MIDDLE E. LAST CONNOLLY

15. MOTHER'S MAIDEN NAME FIRST CARRIE MIDDLE LAST AULENBACH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 196-05-4686

17. INFORMANT ADDRESS: KATHRYN CONNOLLY/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Pacemaker

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 2-16-89

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. — ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: FEB 18,1989 — 23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEMETERY — 23d. LOCATION CITY OR TOWN: SILVER SPRING COUNTY: MONTGOMERY STATE: MD

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 — 25a. DATE REC'D. BY REGISTRAR: FEB 17'89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINERS: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 1041

DHMH - 17 (VR A15 ME (5))

024292 FEB 29 89 — 1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05764 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Donald / James / CONWAY	2a. DATE OF DEATH — MONTH DAY YEAR	February 22, 1989	2b. HOUR	7:23P M
3. SEX	Male	4. RACE	Caucasian	5. DATE OF BIRTH — MONTH DAY YEAR	Oct. 31, 1915
6. AGE (IN YEARS LAST BIRTHDAY)	73 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Canada	7b. CITIZEN OF WHAT COUNTRY?	United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George's County MD.				
10. CITY OR TOWN OF DEATH	Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	AMI Doctor's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Manager
12b. KIND OF BUSINESS OR INDUSTRY	Service Station				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Bowie	YES ☒ NO ☐	13003 9th Street/20715

14. FATHER'S NAME — FIRST / MIDDLE / LAST	George / / Conway	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Margaret / / Donnally

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1941-1945	218-03-5069	Kenneth T. Conway	14201 Lancaster Lane Bowie, MD 20715

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio Pulmonary Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Aortic Regurgitation	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐ XX	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 2 11 19 89 to 2 22 19 89, that (I) (we) last saw the deceased alive on 2 22 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Rajan Sood M.D.	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2 23 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Rajan Sood, M.D.	6811 Laurel-Bowie Rd. Bowie, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	Feb. 25, 1989	Ft. LIncoln Cemetery	Brentwood, P.G., Maryland

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	MAR 1 - 1989	Julia Knudsen-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024978 MAR 1-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05765
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Gerald	MIDDLE: FELIX	LAST: Corley	2a. DATE OF DEATH MONTH DAY YEAR: 02 04 89	2b. HOUR: 2:42 P M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: MARCH 4, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): POSTAL WORKER	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Post Office		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: —	13b. COUNTY: —	13c. CITY OR TOWN: WASHINGTON, D.C.	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 2700 31ST ST. SE. / 20020	
14. FATHER'S NAME FIRST / MIDDLE / LAST: ALBERT / P. / CORLEY		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: MARY / — / DULL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 714-07-9045	17. INFORMANT: HAZEL CORLEY (WIFE)	ADDRESS: 2700 31ST ST. SE. WASHINGTON, D.C. 20020		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): acute Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (c): Cardiac arrythmia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from JAN. 18, 19 89 to FEB. 4, 19 89, that I (we) last saw the deceased alive on FEB. 4, 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Smit	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: FEB. 4, 1989
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES SMIT, M.D.	22e. ADDRESS: 7503 SURRATTS RD. CLINTON, MARYLAND 20735	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 9, 1989	23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: ARLINGTON, ARLINGTON CO. VIRGINIA
24. FUNERAL DIRECTOR NAME / ADDRESS: ROBERT E. WILHELM, INC. 4308 SUITLAND RD. SUITLAND, MD.	25a. DATE REC'D. BY REGISTRAR: FEB 10 '89	25b. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall	

BP

DHMH 10-50M 4/88 (VRA 15, 4)

024047 FEB 28 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 05766 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21a is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: ETHEL	MIDDLE: E.	LAST: COUSINS	2a. DATE OF DEATH: MONTH 02 DAY 21 YEAR 89	2b. HOUR: 12 15P M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH: MONTH 9 DAY 29 YEAR 1908	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET AND NUMBER OR LOCATION): PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: PG	13c. CITY OR TOWN: Glenarden	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 1504-5th Street, Glenarden, MD 20706	
14. FATHER'S NAME: FIRST Charles MIDDLE LAST Wilson			15. MOTHER'S MAIDEN NAME: FIRST Sheldonia MIDDLE LAST Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 710-18-5245	17. INFORMANT: James R. Cousins III	ADDRESS: Glenarden, MD 8626 Leslie Ave. 20706	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC ARREST	MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b)	SEPTIC SHOCK	HOURS
DUE TO, OR AS A CONSEQUENCE OF (c)	BACTREMIA FROM NECROTIC SKIN	DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: PARKINSONS DISEASE, DIABETES MELLITUS, HYPERTENSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George Bone	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/21/89	
22f. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE BONE	22e. ADDRESS: 8601 MLK JR HWY LANHAM.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 28 Feb 89	23c. NAME OF CEMETERY OR CREMATORY: Maryland Nat'l. Ceme.	23d. LOCATION: CITY OR TOWN: Laurel	COUNTY: PG	STATE: MD
24. FUNERAL DIRECTOR: NAME / ADDRESS: JB Jenkins FH/7474 Landover Rd. Landover, MD		25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Q23407 FEB 22-89 FOR STATE REGISTRAR

Items 18a thru 22a Per Film G653 7726/89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05767 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Renee	Elisa	Crayton	1-	22-	1989	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR	2d. HOUR
FEMALE	BLACK	9	16	87	YRS.					1-	22-	1989	2:48P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	UNITED STATES		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Camp Springs	Andrews Air Force Base	NONE	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
MD.	P.G.	PALMER PARK		2300 PENN BROOK CIRCLE

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ERIC		McCUTCHEN	DENEEN	CRAYTON	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO			DENEEN CRAYTON SAMEAS 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning complicating seizure disorder
7999
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	1/22 1989	Subject drowned in bath tub

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	Home	6804 Atwood St.	District Heights	PG	Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 1-23-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2-1-89	HARMONY CEM	LANDOVER,	MD.	

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRAZIER'S FUNERAL HOME	389 RINP WASH, DC.	FEB 10 1989	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGES 1 AND 2 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0230015 DEC 15 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057688
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
	Max	Thomas	Crush		2	7	89	4:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
		MONTH DAY YEAR		MONTHS	DAYS	HOURS	MIN.
Male	White	Aug 20 1914	74 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	USA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CLINTON	SOUTHERN MD. HOSP. CENTER	Manager	Parking Fac.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Pr George	Forestville	YES ☐ NO ☐	6037 Parkland Court #202 20747

14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST
	John	L.	Crush		Edna	Jane	Garst

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		225 01 6535	Shirley Arthur	9014 Littleton St Fairfax Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Left Side Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c) Atrial fibrillation

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/14/ 19 89 to 2/7/ 19 89 that (I) (we) last saw the deceased alive on 2/7/ 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
	M.D	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Laxmi Berwa	1300 Mercantile Lane #134 Landover Md 20785

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	Feb 9 89	Resurrection Cemetery	Clinton		Maryland

24. FUNERAL DIRECTOR NAME	DATE RECD. BY REGISTRAR	25. REGISTRAR'S SIGNATURE
Robert E Wilhelm FunerAL Home 4308 Suitland Rd Suitland Maryland	DEC 9 '89	Julia Davidson-Randall

024772 MAR - 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05769
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The plastic remover carbon paper on Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: C.	LAST: Daniels	2a. DATE OF DEATH MONTH: 2	DAY: 18	YEAR: 89
2b. HOUR: 11A M					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 12	DAY: 31	YEAR: 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.		
10. CITY OR TOWN OF DEATH: Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EITHER FACILITY, GIVE STREET ADDRESS): Leland Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Telephone Operator	12b. KIND OF BUSINESS OR INDUSTRY: Hospital		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Hyattsville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 4004 Queensbury Road 20782	
14. FATHER'S NAME FIRST: William	MIDDLE	LAST: Adamson	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: C.	LAST: Davis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 215-18-9822	17. INFORMANT: ((Daughter) ADDRESS: ~~2218~~ Kempton Road Carol A. Bennette Lanham, Md. 20706		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain Tumor — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Wks
DUE TO, OR AS A CONSEQUENCE OF (b): Subdural Hematoma days
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 89 to 2/18 19 89 that (I) (we) last saw the deceased alive on 2/17 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Surinder Singh DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 2/18/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): SURINDER SINGH
22e. ADDRESS: 4700 Berwyn House Rd. Suite 101. College Park, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/21/89	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN: Brentwood	COUNTY: P.G. STATE: Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781
25a. DATE REC'D. BY REGISTRAR: FEB 21 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(10) BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024969 MAR 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 89 05770

1. DECEASED NAME (TYPE OR PRINT) — FIRST: GLEN — MIDDLE: ELLIOT — LAST: DAVIS

2a. DATE OF DEATH — MONTH DAY YEAR: February 20, 1989

2b. HOUR: 6:00 AM

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH DAY YEAR: 04-25-1959

6. AGE (IN YEARS LAST BIRTHDAY): 29 YRS — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington DC

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Bladensburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5999 Emerson Street, Apt. 519

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): painter

12b. KIND OF BUSINESS OR INDUSTRY: Painting Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: P.G.

13c. CITY OR TOWN: Bladensburg

13d. INSIDE CITY LIMITS? YES X NO ☐

13e. STREET ADDRESS: 5999 Emerson St., #519 20710

14. FATHER'S NAME — FIRST: Frank — MIDDLE: E. — LAST: Davis

15. MOTHER'S MAIDEN NAME — FIRST: Mary — MIDDLE: — LAST: Robinson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 218-78-2188

17. INFORMANT: 5999 Emerson Street, Bladensburg, Mary Davis, Md. 20710 #805

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypovolemic
DUE TO, OR AS A CONSEQUENCE OF (b): Ruptured Bowel
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes many

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Failure Coronary heart disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO XX

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/4/66 19____, to 2/20, 19 89, that (we) last saw the deceased alive on 2/19 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Frederick H. Wilhelm — DEGREE: ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 02-20-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frederick H. Wilhelm, M.D.

22e. ADDRESS: 5807 Annapolis Rd., Hyattsville, Md. 20784

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02-23-89

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION — CITY OR TOWN COUNTY STATE: Brentwood, P.G., Maryland

24. FUNERAL DIRECTOR (SIGNATURE): FRANCIS GASCH'S SONS FUNERAL HOME, P.A.
4739 Baltimore Ave., Hyattsville, Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 21 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
RELEASED BY D.M.E., DR. DEVORE TO FAMILY PHYSICIAN 02-20-89

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. To please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 1650M 1/81 (VRA 15, 4)

024957 MAR -8 89p FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05771 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. DECEASED NAME (TYPE OR PRINT) First: James	Middle: Arthur	Last: Davis	2a. DATE OF DEATH Month Day Year: February 22, 1989	2b. HOUR: 11:28p M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: 08 09 17	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Texas	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Industrial Eng.	12b. KIND OF BUSINESS OR INDUSTRY: Manufacturing		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: PG	13c. CITY OR TOWN: College Park	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 4711 Berwyn House Road, #314	20740
14. FATHER'S NAME First: Arthur	Middle: Isaac	Last: Davis	15. MOTHER'S MAIDEN NAME First: Annie	Middle: Erma	Last: Hoover
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 557-20-0583	17. INFORMANT: Louise Davis	ADDRESS: 4711 Berwyn House Rd, 314 College Park, Md 20740	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b): Ischaemic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c): Cardiac arrhythmia.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hour

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-21 19 89 to 2-22- 19 89, that (I) (we) last saw the deceased alive on 2-22 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A Hussain. DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED:
22d. PHYSICIAN'S NAME (TYPE OR PRINT): AZHER HUSSAIN
22e. ADDRESS: 4917, Edgewood Rd College park MD 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/27/89	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN: Brentwood COUNTY: PG STATE: Maryland	
24. FUNERAL DIRECTOR NAME: Francis Gasch's Sons Funeral Home, PA ADDRESS: 4739 Baltimore Ave., Hyattsville, MD 20781		DATE REC'D BY REGISTRAR: FEB 28 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

0252884 MAR 14 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005772

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	William	H.	DEAVERS

2a. DATE OF DEATH: February 13, 1989 — 2b. HOUR: 9:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR (MONTHS / DAYS)	IF UNDER 24 HRS (HOURS / MIN.)
MALE	CAUCASIAN	FEB 14 1904	84 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
WASHINGTON, DC	USA		Prince George's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	AMI Doctors' Hospital of PG County	PLUMBER	JULIAS BECKER

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	PR GEORGES	GLENN DALE	YES ☐ NO ☐	11023 BROOKLAND ROAD 20769

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
WILLIAM H. DEAVERS, SR.	MARY E. UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		578-07-9569	MADELINE SPAULDING/DAUGHTER/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-7 19 89 to 2-13 19 89, that (I) (we) last saw the deceased alive on 2-7 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Richard Lilly	MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	FEB 14, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. RICHARD LILLY, M.D.	5804 BALTIMORE AVENUE HYATTSVILLE, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 17, 1989	FT. LINCOLN CEMETERY	BRENTWOOD PRINCE GEORGES MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 17 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

025093 MAR 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05773 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
GIOVINA		DICAMILLO	02/15/89	1.35A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	Oct. 12, 1892	96 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Italy	Italy		PRINCE GEORGE MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGES HOSP. CENTER	Homemaker	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	P.G.	Riverdale	YES ☒ NO ☐	5910 Goodluck Rd. /20737

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Camillo	-	Giancristofaro	Chiara	-	Pelliciotti

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	------	220-50-7250	Angela M. DiCamillo	Same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

IMMEDIATE CAUSE (a) Cadiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Subdural Hematoma
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/4/1989	Acute Subdural Hematoma	YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/4, 19 89, to 2/24, 19 89, that (I) (we) last saw the deceased alive on 2/24, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Najmaddin O. Karim	M.D.		2/25/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Najmaddin Karim	7500 Hanover Parkway #204 Greenbelt MD. 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/28/89	Mt. Olivet Cemetery	Washington D.C.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W.W.Chambers Co. Inc.	5801 Cleveland Ave. Riverdale, MD. 20737	FEB 27 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

022098 FEB-9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05774
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: George	MIDDLE: C.	LAST: Doering	2a. DATE OF DEATH MONTH DAY YEAR: 2-3-89	2b. HOUR: 0700 A M
3. SEX: MALE	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: 4/21/10	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George county MD.	
10. CITY OR TOWN OF DEATH: LAUREL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Lawyer Attorney	12b. KIND OF BUSINESS OR INDUSTRY: Railroad B&O	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Mitchellville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 11905 Chantilly Lane 20716
14. FATHER'S NAME FIRST: Charles	MIDDLE: E.	LAST: Doering	15. MOTHER'S MAIDEN NAME FIRST: Lucy	MIDDLE: L. LAST: Cooper
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 715-18-5085	17. INFORMANT: Janet H. Doering (wife)	ADDRESS: same as # 13.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b): CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CONGESTIVE HEART FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/16 19 88 to 2/3 19 89, that (I) (we) last saw the deceased alive on 1/24 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2-3-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. A. COMPTON MD

22e. ADDRESS: 8317 CHERRY LANE LAUREL MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2-4-1989	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crem.	23d. LOCATION CITY OR TOWN: Alexandria COUNTY: Fairfax STATE: VA.	
24. FUNERAL DIRECTOR NAME: Donald Borgwardt ADDRESS: 4400 Powder Mill Rd. Beltsville, Md. 20705		25a. DATE REC'D. BY REGISTRAR: FEB 7 1989	25b. REGISTRAR'S SIGNATURE: [signature]	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023852 FEB 2 1989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05775
REG. NO.

FOR STATE REGISTRAR Gabriel A. Dolenga-Kovalevsky

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: GABRIEL MIDDLE: A. LAST: DOLENGA-KOVALEVSKY			2a. DATE OF DEATH MONTH DAY YEAR: 2 · 5 · 89	2b. HOUR: 6.40 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 26, 1893	6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Russia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SO. MARYLAND HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Unknown	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Pr.Georges	Forestville	YES ☒ NO ☐	7420-Marlboro Pike 20747

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown	Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	094-09-4207	Munsey Bldg. 7-N.Calvert St., Baltimore, MD 21202-1993 George V. Parkhurst (Attorney) Suite #1214

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 d.
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Carcinoma of prostate. Bony metastases; Hypertensive Heart Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 70 to Feb 5 19 89 that (I (we) last saw the deceased alive on Feb 5 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
J. Sanford Young	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. Sanford Young, MD	11701-Livingston Rd., Ft. Washington, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	Feb. 11, 1989	Lee's Crematory	Washington, D.C.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
J. William Lee's Sons Co. 300-4th St., NE, Wash., DC 20002	FEB 21 1989	Jackie Davidson-Randall

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

024025 FEB 23 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05776 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (it contains the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 24a is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARION	MIDDLE: E.	LAST: DONALDSON	2a. DATE OF DEATH MONTH DAY YEAR: 2/17/89	2b. HOUR: 2.37A M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 26 1920	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Bowie, Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE MD.	
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGES HSPTL. CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cigarette Stamper	12b. KIND OF BUSINESS OR INDUSTRY: Safeway

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Anne Arundel	Crofton	YES ☒ NO ☐	923 Eastham Ct. Apt 21 21114

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John		Boswell	Mary	Josephine	Deutch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		579-22-3335	Carol Krueger Same as 13e Daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sepsis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CANCER

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: massive Recurrent Carcinoma of tongue

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/8 1/23, 19 89, to 2/14, 19 89, that (I) (we) last saw the deceased alive on 2/14, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John BIEDLINGMAIER	6202 GARDNER ST BOWIE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2- 20-89	Sacred Heart Church	Bowie Prince Georges Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	24a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A. 16000 Annapolis Road Bowie, Maryland	FEB 23 1989	Julia Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

25080 MAR -9 89

FOR 1 - STATE REGISTRAR Film G649 item 17 3-15-89 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05777
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: ALBERT	MIDDLE: ERNEST	LAST: DONNELLY	2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐	MONTH: 2	DAY: 19	YEAR: 89	2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 12 DAY: 21 YEAR: 26	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YR. MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN.	2c. DATE PRONOUNCED DEAD MONTH: 2 DAY: 19 YEAR: 89		2d. HOUR: 1103 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George's General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mgmt. Analyst	12b. KIND OF BUSINESS/INDUSTRY: Federal Government

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Hyattsville	YES ☒ NO ☐	6107 Otis Street 20785

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST: Carroll	MIDDLE: Vincent	LAST: Donnelly	FIRST: Anna	MIDDLE: Lynn	LAST: Webster

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (SPECIFY NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (TYPE OR PRINT) NAME, RELATIONSHIP, AND ADDRESS
Yes-Army	WWII	578-28-5022	Carolyn (Sister) 6107 Otis Street Carolyn Donnelly Hyattsville, Md. 20785

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER
DATE SIGNED: 2-21-89
EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez MD
ADDRESS: 5009 Rayburn Ct. Cp. Gr., Pr. Geo. Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/24/89	Fort Lincoln Cemetery	Brentwood P.G. Maryland

24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore AVenue Hyattsville, Md. 20781	FEB 23 '89	Lillian Feidler-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP____ DHMH - 17 (VR A15 ME (5))

23165 FEB 23 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05778
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: LeDane	LAST: Dorough	2a. DATE OF DEATH MONTH DAY YEAR: 1-9-89	2b. HOUR: 10:30 A M	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Aug 22 1914	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Oklahoma City, Okla.	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9700 Snowden Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer (Ret)	12b. KIND OF BUSINESS OR INDUSTRY: Railroad		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Laurel	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 9700 Snowden Road 20708	
14. FATHER'S NAME FIRST: John	MIDDLE: Levi	LAST: Dorough	15. MOTHER'S MAIDEN NAME FIRST: Frustina	MIDDLE: Olive	LAST: Johnson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): n/a	(IF YES, GIVE WAR OR DATES): n/a	16b. SOCIAL SECURITY NO.: 578-20-0263	17. INFORMANT ADDRESS: Barbara Ann Taylor 3202 Marcando Ln. Upper Marlboro, Md. 20772		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Ventricular Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from July 19 77, to 1-9- 19 89, that (I) (we) last saw the deceased alive on 12/23/88 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William A Warren DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1-9-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): William A Warren — 22e. ADDRESS: 321 Prince Georges ST

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/12/89	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Brentwood Prince George's Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Md. 20707	25a. DATE REC'D. BY REGISTRAR: JAN 11 '89	25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024838 MAR - 7 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05779 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: John	MIDDLE: A.	LAST: Dougherty	2a. DATE OF DEATH MONTH DAY YEAR: February 25, 1989	2b. HOUR: 11:30 P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 4 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges Hospital Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Lithographer	12b. KIND OF BUSINESS OR INDUSTRY: Fed'l. Gov't.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. Georges	13c. CITY OR TOWN: Forestville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 2519 Newglen Ave. 20747	
14. FATHER'S NAME FIRST: William	MIDDLE: B.	LAST: Dougherty	15. MOTHER'S MAIDEN NAME FIRST: Leona	MIDDLE:	LAST: Andrews
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	IF YES, GIVE WAR OR DATES:	16b. SOCIAL SECURITY NO.: 579-07-7191	17. INFORMANT: Margaret G. Dougherty	ADDRESS: as in item 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Liver
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) [X] attended the deceased from October, 1988, to February 25, 1989, that (I) [X] last saw the deceased alive on February 25, 1989, and that in (my) [X] opinion death occurred at the date and hour and from the causes stated above, (I) [X] did) (did not) view the body after death.

22b. SIGNATURE: Clark Holmes, MD DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/26/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Clark Holmes M.D.
22e. ADDRESS: 14314 Old Marlboro Pike Upper Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 3-1-89	23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery	23d. LOCATION CITY OR TOWN: Clinton	COUNTY: P.G. STATE: Md
24. FUNERAL DIRECTOR NAME / ADDRESS: G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.	25a. DATE REC'D. BY REGISTRAR: MAR 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

MAR 01 '89 Julia Davidson-Randall

DHMH - 1650M 1/81 (VRA 15, 4)

BP_____

024919 MAR-3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05780 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST						2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR 19	2b. HOUR
Oswald	George	Douglas, Jr.						1-31-		89	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR 19	2d. HOUR
MALE	BLACK	August	26,	1956	32 YRS.					1-31-		89	3:40A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	U.S.A.		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Suitland	5700 Block Suitland Road at Regency Pkwy.	Mail Handler	Government

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS
MD.	Prince Georges	Clinton		6712 Fulford Street 20735

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE LAST
Oswald	George	Douglas, Sr.	Inez	Hines

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	118-54-6084	Robyn Brown-Douglas	6712 Fulford Rd Clinton, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple injuries	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8120	DUE TO, OR AS A CONSEQUENCE OF (b)	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	2:25AM 1-31-89	Driver in auto/auto collision

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
	road	5700 block Suitland Road at Regency Pkwy. Prince Georges County MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 1-31-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	February 3, 1989	Calverton Cemetery	Long Island, New York	
24a. FUNERAL DIRECTOR NAME	ADDRESS	24b. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
John T. Stewart, III Stewart Funeral Home	4001 Benning Rd., Wash. D.C.	FEB 10 '89	Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024594 MAR - 5 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05781
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Thomas	MIDDLE: Clarence	LAST: Dowdle, III			
2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ]	MONTH: 2	DAY: 26	YEAR: 19 89	2b. HOUR: M		
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH: MONTH MAY DAY 15 YEAR 1960	6. AGE (IN YEARS LAST BIRTHDAY): 28 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	
2c. DATE PRONOUNCED DEAD	MONTH: 2	DAY: 26	YEAR: 19 89	2d. HOUR: 7:36 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.			
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ELEC. TECH.	12b. KIND OF BUSINESS OR INDUSTRY: PRIVATE IND.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: D.C.	13b. COUNTY: N/A	13c. CITY OR TOWN: WASH.	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 2336 25TH ST, S.E.		
14. FATHER'S NAME: FIRST THOMAS MIDDLE C. LAST DOWDLE, JR.	15. MOTHER'S MAIDEN NAME: FIRST CAROLYN MIDDLE FEMISTER LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): '86 - '92	16b. SOCIAL SECURITY NO.: 214-78-9831	17. INFORMANT: CAROLYN DOWDLE	ADDRESS: SAME AS #13 ABOVE		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple injuries	
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. 6:25 PM MONTH 2 DAY 26 YEAR 19 89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Passenger in auto/auto collision	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): street	21f. LOCATION STREET: Central Avenue/Pepper Mill Drive, CITY OR TOWN: Seat Pleasant, COUNTY: Prince Geo. County, STATE: Maryland	

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], Opinion [ ]; death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE OF M.D. MEDICAL EXAMINER: Thomas F. Hale for — TITLE (SPECIFY): Acting Deputy Chief — DATE SIGNED: 2-27-89

EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
	3/3/89	HARMONY MEM. PK.	LANDOVER P.G. MD.

24. FUNERAL DIRECTOR NAME: W. S. WASHINGTON & SONS — ADDRESS: 4625 Bunker Hill Rd. Hyatt

25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH 417
(VR-A15 ME (5))

24940

940 MAR -8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 05782

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: FLORENCE MIDDLE: L. LAST: DUNLAP				2a. DATE OF DEATH MONTH DAY YEAR: 2/26/89	2b. HOUR: 5.30A M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 8 17 10	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS. HOURS MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: at home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. George	13c. CITY OR TOWN: Camp Springs	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS / ZIP CODE: 6723 Edgemere Dr. 20748	
14. FATHER'S NAME FIRST: Charles MIDDLE: LAST: Baker			15. MOTHER'S MAIDEN NAME FIRST: Julia MIDDLE: LAST: Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 577-92-8435	17. INFORMANT: Julia Myers	ADDRESS: same as item 13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic Bowel
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Thyroid Cancer.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES X NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES XX NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 25 19 89 to Feb 26 19 89, that I (we) last saw the deceased alive on Feb 25 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

22b. SIGNATURE: Stuart Turkewitz	DEGREE: MD ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/26/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stuart Turkewitz	22e. ADDRESS: 7500 Greenway Center Dr. Greenbelt, Md. 20770	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 3/4/89	23c. NAME OF CEMETERY OR CREMATORY: Washington Nat. Cemetery	23d. LOCATION CITY OR TOWN: Suitland COUNTY: P.G. STATE: Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS: G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D BY REGISTRAR: MAR 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

0249.86 MAR - 9 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 005783

1. DECEASED NAME (TYPE OR PRINT): First George; Middle Robert; Last Durham

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month Feb Day 11 Year 19 89 — 2b. HOUR 930 A.M.

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: Month Dec Day 15 Year 1923 — 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. — IF UNDER 1 YR.: Months, Days — IF UNDER 24 HRS.: Hours, Min.

2c. DATE PRONOUNCED DEAD: Month Feb Day 11 Year 19 89 — 2d. HOUR 930 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County

10. CITY OR TOWN OF DEATH: Brentwood — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL OR FACILITY, GIVE STREET ADDRESS): 3400 Taylor Street — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Auto Mechanic — 12b. KIND OF BUSINESS OR INDUSTRY: Triangle Ford

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: Brentwood — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 3400 Taylor Street 20722

14. FATHER'S NAME: First John; Middle; Last Durham — 15. MOTHER'S MAIDEN NAME: First Caroline; Middle; Last (Unavailable)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 231-16-5587 — 17. INFORMANT: (Wife) 3400 Taylor Street — ADDRESS: Hazel V. Durham Brentwood, Md. 20722

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Feb 11 1989

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. — ADDRESS: 1919 Seminary Road Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 02/14/89 — 23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery — 23d. LOCATION CITY OR TOWN: Rockville; COUNTY: Montgomery; STATE: Maryland

24. FUNERAL DIRECTOR: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781 — 25a. DATE REC'D. BY REGISTRAR: FEB 17 '89 — 25b. REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0249 2.2 MAR -8 89

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 057834

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	Jerome	Cortlan	Dyer, Jr.

2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] — MONTH DAY YEAR: 2-5-19 89 — 2b. HOUR: M

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	BLACK	November 8, 1971	17 YRS.				

2c. DATE PRONOUNCED DEAD (MONTH DAY YEAR): 2-5-19 89 — 2d. HOUR: 11:10 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, D.C.	U.S.A.	MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Suitland	3913 Southern Avenue	High School Student	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	Prince Georges	Suitland	YES [ ] NO [X]	3901 Suitland Road 20746

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Cortlan	Jerome	Dyer	Joyce	Ann	Vernon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	579-08-1514	Joyce A. Vernon	3901 Suitland Road Suitland, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot wound of back of chest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [XX] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	2-5-89	Subject shot

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ] [XX]	walkway	3913 Southern Avenue	Suitland,	Prince Geo. County, MD	

22a. I certify that I took charge of the remains described above and on Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [XX], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED: 2-6-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes,M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	February 11, 1989	Lincoln Memorial	Suitland,	Maryland	

24a. SIGNATURE OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH: John T. Stewart, III — ADDRESS: 4001 Benning Rd., N.E. — 25a. DATE RECD. BY REGISTRAR: FEB 10 89 — 25b. REGISTRAR'S SIGNATURE: [signature]

Stewart Funeral Home Washington, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024386 MAR -2 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005785

1. DECEASED NAME (TYPE OR PRINT) FIRST: Debra	MIDDLE: L.	LAST: Earwicker	2a. DATE OF DEATH MONTH DAY YEAR: 1/13/89	2b. HOUR: 3 13 M		
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: 12 21 57	6. AGE (IN YEARS LAST BIRTHDAY): 31 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.			
10. CITY OR TOWN OF DEATH: Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Beltsville Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: ~~Howard~~ Anne Arundel	13c. CITY OR TOWN: Hanover	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 6430 Anderson Ave. 21076		
14. FATHER'S NAME FIRST: Alfred	MIDDLE: A.	LAST: Kirby, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Georgetta	MIDDLE: M.	LAST: Brandenburg	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 237-13-5368	17. INFORMANT: Donald D. Earwicker, 6430 Anderson Ave.	ADDRESS: Hanover, Md. 21076		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Renal Cardiac
DUE TO, OR AS A CONSEQUENCE OF (c): Chronic Renal failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C.R. Nath	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 1/13/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): C.R. NATH, M.D.	22e. ADDRESS: 14300 Gallant Fox Ln Bowie, MD 20715		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/16/89	23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk.	23d. LOCATION CITY OR TOWN: Elkridge	COUNTY: Howard STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Gary L. Kaufman, 5695 Main St., Elkridge, Md. 21227	25a. DATE REC'D BY REGISTRAR: JAN 17 89	25b. REGISTRAR'S SIGNATURE: [signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 8

DHMH - 16 50M 1/81 (VRA 15, 4)

025092 MAR-9 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05786
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Andrew	Bennitt	ECKERSON	February 22, 1989	8:40P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	Caucasian	August 25, 1917	71 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
New Jersey	U.S.A.		Prince George's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	A.M.I. Doctor's Hospital	Psychologist	U.S. Labor

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince Geo.	Mitchellville	YES X NO	20716 10450 Lottsford Road#220 Dept.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Andrew	Jackson	Eckerson	Ida	May	Bennitt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	151-12-3621	Louise O. Eckerson	10450 LottsfordRd Mitchellville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ASPIRATION PNEUMONITIS	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	ADVANCED CIRRHOSIS (LAENNEC'S) & ASCITES (TEMPE)	1 YEAR
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SEVERE CACHEXIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES / NO X	YES / NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M./P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 22 19 89 to Feb 22 19 89, that (I) (we) last saw the deceased alive on Feb 22 19 89 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	MD ATTENDING PHYSICIAN X / MEDICAL DIRECTOR / STAFF PHYSICIAN	2/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
P SCHISSLER MD	7500 Greenway Ctr Dr Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Removal	Feb. 23, 1989	George Washington Medical School	Wash. D.C

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Columbia Mortuary Services 225 Missouri Ave. N.W. Washington D.C.	FEB 24 '89	Julia Davidson-Randall

20011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025302 MAR 1

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005787

1. DECEASED NAME (TYPE OR PRINT): FIRST Mary MIDDLE B. LAST Edwards

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH Feb DAY 12 YEAR 19 89 — 2b. HOUR 8:20 A.M.

3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH: MONTH Nov DAY 18 YEAR 15 — 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 12 YEAR 19 89 — 2d. HOUR 8:20 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VIRGINIA — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.

10. CITY OR TOWN OF DEATH: BERWYN HEIGHTS — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5713 SEMINOLE STREET

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ADMIN ASSISTANT — 12b. KIND OF BUSINESS OR INDUSTRY: UNIV MD GEOGRAPHY DEPT.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Silver Spg — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 1600 Tilton Dr. 20902

14. FATHER'S NAME: FIRST JAMES MIDDLE B. LAST BLANDFORD

15. MOTHER'S MAIDEN NAME: FIRST JOSEPHINE MIDDLE LAST JARBOE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-03-3090

17. INFORMANT: SON — ADDRESS: 14236 BRADSHAW DR. MICHAEL B. EDWARDS SILVER SPRING, MD 20904

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Dis

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Myocardial Dis

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S Rogers M.D. — TITLE (SPECIFY): Dep MEDICAL EXAMINER — DATE SIGNED: Feb 12, 1989

EXAMINER'S NAME (TYPE OR PRINT): JOHN S. ROGERS, M.D. — ADDRESS: 1919 SEMINARY ROAD SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: FEB 16, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: ST. JOHN'S CEMETERY — 23d. LOCATION CITY OR TOWN: CLINTON COUNTY: PRINCE GEORGES STATE: MD

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 — 25a. DATE REC'D. BY REGISTRAR: FEB 15 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M

BP 10

DHMH - 17 (VR A15 ME (5))

024608 MAR 3 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057883
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CLIFFORD	MIDDLE: W.	LAST: EPPLEY	2a. DATE OF DEATH MONTH/DAY/YEAR: 2/27/89	2b. HOUR: 3:[illegible] A.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH/DAY/YEAR: Sept. 13 1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bldg. Contractor	12b. KIND OF BUSINESS OR INDUSTRY: self employed	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Pr. Georges	Beltsville	YES [X] NO [ ]	13220 Greenmount Ave., 20705

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Frank / / Eppley	Minnie / / Manges

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
N/A	N/A	172-03-6800	Erlene Eppley-wife- (same as 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): COMPLETE HEART BLOCK

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CALDIO MYOPATHY

DUE TO, OR AS A CONSEQUENCE OF (c): VENTRICULAR ARRHYTHMIA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: ADULT RESPIRATORY DISTRESS SYNDROME, PNEUMONIA, LUNG ABSCESS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/15	LUNG ABSCESS	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from AUG 19 83 to PRESENT 19 ____, that (I) (we) last saw the deceased alive on 2/26 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] 22c. DATE SIGNED: 2/27/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ESMACHADO 22e. ADDRESS: 321 Prince George St. Laurel, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3-1-1989	Md. Natl. Memorial	Laurel Prince Georges Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HInes/Rinaldi Funeral Home 11800 N.H. Ave., Sil. Spr., Md.	MAR 1 - 1989	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

025078 MAR - 9 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05789
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE:	LAST: ERLENBACH	2a. DATE OF DEATH MONTH DAY YEAR: Feb 20 1989	2b. HOUR: 4:15 AM	
3. SEX: F	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 12 05 97	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS.	IF UNDER 1 YEAR MONTHS / DAYS:	IF UNDER 24 HRS. HOURS / MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.		
10. CITY OR TOWN OF DEATH: MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Manor Care	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Gov't Employee	12b. KIND OF BUSINESS OR INDUSTRY: Fed. Home Loan Bank Board		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	P.G.	Forestville	YES ☒ NO ☐	6608 Juneau Street 20747

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	J.	Ryan	Mary	E.	Wander

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	----------	577 58 6786	Joseph A. Norris/same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebrovascular Accident

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive Heart Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from December 19 88 to Feb 19 1989, that (I) (we) last saw the deceased alive on Feb 7 19 89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stuart Turkewitz DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/20/89.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stuart Turkewitz 22e. ADDRESS: 7500 Greenway Cat. Dr. Greenbelt, Md. 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb/23/89	Cedar Hill Cemetery	Suitland PG MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert E Wilhelm Funeral Home	Suitland MD	FEB 23 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6 BP

DHMH - 16.60M 7/84
(VRA 15, 4)

22317 FEB 10 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005790

1. DECEASED NAME (TYPE OR PRINT): FIRST Teresa MIDDLE LAST Escobar

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH Feb DAY 2 YEAR 1989

2b. HOUR 5:14 A.M.

3. SEX: F

4. RACE: HISPANIC

5. DATE OF BIRTH: MONTH July DAY 23 YEAR 11

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH DAY Feb 2 YEAR 1989

2d. HOUR 5:42 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ElSalvador

7b. CITIZEN OF WHAT COUNTRY? Resident

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.

10. CITY OR TOWN OF DEATH: Riverdale

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Mem. Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Prince Georges

13c. CITY OR TOWN: Mt. Rainier

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 3110 Winston Rd. 20712

14. FATHER'S NAME: FIRST Emeterio MIDDLE LAST Escobar

15. MOTHER'S MAIDEN NAME: FIRST Basilia MIDDLE LAST Flores

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: N/A

17. INFORMANT: Liliana Hanson (Daughter) ADDRESS: Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Disv
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Rogers M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER DATE SIGNED: Feb 1, 89

EXAMINER'S NAME (TYPE OR PRINT): Dr. John Rogers ADDRESS: 1919 Seminary Rd. S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/10/89

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

23d. LOCATION CITY OR TOWN: Washington D.C. COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md

25a. DATE RECD. BY REGISTRAR: FEB 09 1989

REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024613 MAR 2 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

89 05791 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT): FIRST Robert MIDDLE J. LAST Evans, Sr.

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH Feb. DAY 24 YEAR 89

2b. HOUR 4:35 P.M.

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: MONTH Aug. DAY 27 YEAR 27

6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 24 YEAR 89

2d. HOUR 5:30 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penn

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Laurel

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Beltsville Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Plumber

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md.

13b. COUNTY Prince George's

13c. CITY OR TOWN Beltsville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 4089 Foxview Rd. 20705

14. FATHER'S NAME: FIRST Walter MIDDLE J. LAST Evans

15. MOTHER'S MAIDEN NAME: FIRST Edna MIDDLE LAST McMullen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) Navy

16b. SOCIAL SECURITY NO. 579 26 7075

17. INFORMANT ADDRESS: Marlene P. Evans (Wife) Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Inf

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None

19a. DATE OF OPERATION None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Dep. MEDICAL EXAMINER

DATE SIGNED Feb. 24, 1989

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers MD ADDRESS 1919 Seminary Rd. S.S.Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 2/28/89

23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery

23d. LOCATION CITY OR TOWN Brentwood COUNTY PG STATE Md.

24. FUNERAL DIRECTOR NAME Hines/Rinaldi ADDRESS 11800 New Hamp. Ave. S.S.Md.

25a. DATE REC'D. BY REGISTRAR MAR 1 - 1989

25b. REGISTRAR'S SIGNATURE

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024951 MAR-3 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05792 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
FRANCES	AMILIA	FARLEY	2/	23/	89 / 2 a M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	March 27, 1913	75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Alabama	USA		Prince George's MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly	P.G. G. H.		Housewife	Home 20710	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	P.G.	Bladensburg	YES ☒ NO ☐	5999 Emerson St. Apt. 722/

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
David	Houston	Long	Rilla		Willingham

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	-----	420-18-6540	Frederick Farley	777 University Drive Waldorf, Md. 20602

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Collapse

DUE TO, OR AS A CONSEQUENCE OF

(b) Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) Chronic Obstructive Lung Disease

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 89, to 2-23 19 89, that (I) (we) last saw the deceased alive on 2-23 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Don B Cameron	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-24-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Don B. Cameron, M.D., P.A.	6005 Landover Road Cheverly, Maryland 20785

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	2-24-89	Huntt Crematory	Waldorf	Charles	Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home	P. O. Box 156, Waldorf, Md. 20604-0156	FEB 28 '89	Julia Davidson-Randall

(5) BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023632 FEB 23 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057 93 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The remaining pages (carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to any burial, cremation or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: RICHARD	MIDDLE: Gail	LAST: FINFROCK Sr.	2a. DATE OF DEATH MONTH DAY YEAR: 02-11-89	2b. HOUR: 11 02PM M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 22, 1941	6. AGE (IN YEARS LAST BIRTHDAY): 47 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED X NEVER MARRIED WIDOWED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Finance Officer	12b. KIND OF BUSINESS OR INDUSTRY: Investments		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Prince Georges	Palmer Park	YES NO X	8129 Allendale Dr. 20785

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Vernon	G.	Finfrock	Grace	E.	Sheffler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		213-40-4315	Bettie Lou Finfrock	Palmer Park, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (this hospital) attended the deceased from 1988, 19__, to 2/11, 1989, that I (we) last saw the deceased alive on __, 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did) not view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
for Dr S. Turkewitz	MD	MEDICAL DIRECTOR	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
P SCHISSLER MD	7500 Greenway Ctr Dr Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 15 89	Rest Haven Cemetery	Hagerstown, Wash, Md.

24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Davis Funeral Home	Smithsburg, Md.	FEB 13 '89	Julia Davidson Randall

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 057944 REG. NO.

023928 FEB 23 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: VEARLYN	MIDDLE:	LAST: FLETCHER	2a. DATE OF DEATH: MONTH 02 DAY 16 YEAR 89	2b. HOUR: 1 50PM M
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH: MONTH MAR DAY 21 YEAR 1941	6. AGE (IN YEARS LAST BIRTHDAY): 47 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGES HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECRETARY	12b. KIND OF BUSINESS OR INDUSTRY: PRIVATE INDUS		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
M.D.	P.G.	SEAT PLEASANT	YES ☒ NO ☐	606 CADIN BRANCH DR.

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
WORTHING		MILLS	JOYCE		FLETCHER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		577-54-8121	JOYCE FLETCHER	606 CADIN BRANCH DR. SEAT PLEASANT MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA WITH METASTASIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☑ NO ☐	YES ☑ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-12, 19 89, to 2-16, 19 89, that (I) (we) last saw the deceased alive on 2-16, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Norman Rogers	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-20-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. NORMAN ROGERS	601 EASTERN AVE NE FAIRMONT HGTS, MD 20743

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
BURIAL	2-24-89	HARMONY CEMETERY	LANDOVER P.G. M.D.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019	FEB 23 1989	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

025096 MAR -9 '89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 057955 REG. NO

1. DECEASED NAME (TYPE OR PRINT): Walter Jasper Flynn

2a. DATE OF DEATH: 2/27/89

2b. HOUR: 4.51A M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: 09-19-1900

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.

10. CITY OR TOWN OF DEATH: CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): PRINCE GEORGES HOSPITAL CTR.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Tile Contractor

12b. KIND OF BUSINESS OR INDUSTRY: Self Employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Pr. George's

13c. CITY OR TOWN: Riverdale

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 4911 Somerset Road 20737

14. FATHER'S NAME: William R. Flynn

15. MOTHER'S MAIDEN NAME: Effie E. Walker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 578-07-0226A

17. INFORMANT: Mary B. Flynn

ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Presumed Perforated Ulcer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): high dose Steroid Therapy — 4 months

DUE TO, OR AS A CONSEQUENCE OF (c): Chronic Interstitial Fibrosis — 10-15 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH [ ] (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael Berard, MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. BERARD

22e. ADDRESS: 7305 Baltimore Ave 107 College Park, MD 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 03-03-89

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION: CITY OR TOWN Brentwood COUNTY Pr. George's STATE Md.

24. FUNERAL DIRECTOR: NAME Francis Gasch's Sons Funeral Home, P.A. ADDRESS 4739 Baltimore Avenue, Hyattsville, Md. 20781

25. DATE RECEIVED BY REGISTRAR: MAR 28 89

25. REGISTRAR'S SIGNATURE: Gina Davidson-Randell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

024598 MAR - 3 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05796 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the local registrar in issuing a burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: GREGORY	MIDDLE: J	LAST: FURR, SR.	2a. DATE OF DEATH MONTH: 02	DAY: 13 YEAR: 89
2b. HOUR	5 58P M				
3. SEX	MALE	4. RACE	BLACK	5. DATE OF BIRTH MONTH: 10 DAY: 27 YEAR: 51	
6. AGE (IN YEARS LAST BIRTHDAY)	37 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	D.C.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.
10. CITY OR TOWN OF DEATH	CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Policeman
12b. KIND OF BUSINESS OR INDUSTRY	D.C.Gov't.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	P.G.	13c. CITY OR TOWN	Cap. Hgts.
13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS	20743	421 Birchleaf Ave.		
14. FATHER'S NAME FIRST	Victor	MIDDLE	Lee	LAST	Furr, Sr.
15. MOTHER'S MAIDEN NAME FIRST	Allethia	MIDDLE		LAST	Conley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	577-68-8862
17. INFORMANT	Paulette V. Furr-Same as # 13 above	ADDRESS			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intra Cranial (Cerebral) hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bilateral aspiration pneumonia, respiratory failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-9, 19 89, to 2-13, 19 89, that (I) (we) last saw the deceased alive on 2-13, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	R Rustagi	DEGREE MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED 2/14/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	DR. R.K. RUSTAGI	22e. ADDRESS	6132 Landover Road Cheverly, MD 20785

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	2/18/89	23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem. Park
23d. LOCATION CITY OR TOWN	Landover, Md.	COUNTY	STATE	
24. FUNERAL DIRECTOR NAME	H.S. WASHINGTON + SONS	ADDRESS	4925 Burroughs Ave.	25a. DATE REC'D. BY REGISTRAR MAR 1 - 1989
25b. REGISTRAR'S SIGNATURE	Phila Davidson-Randall			

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

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D.C. U.S.A.

024781 MAR 7 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05797 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Theron	MIDDLE: THERON	LAST: Gaddy GADDY	2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐ MONTH: 2 DAY: 27 YEAR: 1989	2b. HOUR: M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: June 1,1923	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-27 1989	2d. HOUR: 1130 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.		
10. CITY OR TOWN OF DEATH: Capitol Heights	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 939 Balboa Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired/Engineer/US General Services Administration	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: Capitol Heights	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 939 Balboa Avenue, (20743)	
14. FATHER'S NAME FIRST: John	MIDDLE	LAST: Gaddy	15. MOTHER'S MAIDEN NAME FIRST: Alma	MIDDLE	LAST: Baker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes/US Army (IF YES, GIVE WAR OR DATES): 1943 to 1963	16b. SOCIAL SECURITY NO.: 241-20-9933	17. INFORMANT ADDRESS: 939 Balboa Avenue, Capitol Heights, Ruth Elaine Murphy Gaddy(wife) Maryland			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez TITLE (SPECIFY): M.D. MEDICAL EXAMINER DATE SIGNED: 2-27-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, MD ADDRESS: 5009 Rayburn Ct. Cap Hts. Md 20743

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: March 03, 1989	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington County, Virginia
24. FUNERAL DIRECTOR NAME / ADDRESS: LATNEY'S FUNERAL SERVICE, INC. 3831 Georgia Avenue, N.W.; Washington, D.C. 20011	25a. DATE REC'D. BY REGISTRAR: MAR 2 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025158 MAR 13 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 057993 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Zebulon MIDDLE: Vance LAST: Gallop

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ — MONTH DAY YEAR: 2-15 19 89 — 2b. HOUR

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH DAY YEAR: 7-30-96 — 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR: 2-15 19 89 — 2d. HOUR: 1410 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.

10. CITY OR TOWN OF DEATH: Temple Hills — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3405 25th Avenue — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman — 12b. KIND OF BUSINESS OR INDUSTRY: Automobile

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: P.G. Co., — 13c. CITY OR TOWN: Temple Hills — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 3405 25th Ave. / 20748

14. FATHER'S NAME — FIRST: Willis MIDDLE: Hodges LAST: Gallop

15. MOTHER'S MAIDEN NAME — FIRST: Alice MIDDLE: - LAST: O'Neal

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WWI

16b. SOCIAL SECURITY NO.: 578-05-9706

17. INFORMANT ADDRESS: Edith I. Gallop (Wife) Same as # 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, which gave rise to immediate couse (a) stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Prostatic Carcinoma 1968

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-15-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. — ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Feb/21/89 — 23c. NAME OF CEMETERY OR CREMATORY: Maryland Veterans Cemetery — 23d. LOCATION CITY OR TOWN COUNTY STATE: Cheltenham, PG Co, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: Robert E. Wilhelm, Inc. Suitland, Maryland — 25a. DATE REC'D. BY REGISTRAR: FEB 23 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023453
023 GARVIN HARRY FEB 22 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005799
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harry; MIDDLE: O.; LAST: Garvin, Jr.		2a. DATE OF DEATH MONTH DAY YEAR: February 15, 1989	2b. HOUR: 10:30a M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 18, 1954	6. AGE (IN YEARS LAST BIRTHDAY): 34 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.
10. CITY OR TOWN OF DEATH: Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel-Beltsville Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Auto Body

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Mitchellville	YES ☒ NO ☐	12911 Woodmore Road/20716

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Harry O. Garvin, Sr.	Kathleen Sterling		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	**(IF YES, GIVE WAR OR DATES)**	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT / ADDRESS**
No		212-66-4496	Kathleen S. Garvin, Same as # 13.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	1h
DUE TO, OR AS A CONSEQUENCE OF (b)	metastatic malignant melanoma	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/88, 19__, to 2/15, 1989, that (I) (we) last saw the deceased alive on 2/15, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Marvin D. Weltz MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-15-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARVIN D. WELTZ MD	7525 Greenway Ctr Dr Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/17/89	Resurrection Cemetery	Clinton, P.G., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	FEB 21 1989	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

0249 | MAR 8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 005300

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) First: Kathryn	Middle: Louise	Last: Gatlin	2a. DATE KNOWN OF DEATH / ESTIMATED ☐: MONTH XX DAY 2- YEAR 19 89	2b. HOUR		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: MONTH DAY YEAR: Dec 24 1927	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR 2-7- 19 89	2d. HOUR 1:24P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.				
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Printing Co.				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George	13c. CITY OR TOWN: Laurel	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS: 13903 Briarwood Dr Apt813 20708			
14. FATHER'S NAME First: Jesse	Middle: Joseph	Last: Scruggs	15. MOTHER'S MAIDEN NAME First: Anna	Middle: Virginia	Last: Sipe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-40-0345	17. INFORMANT: Stella Logan	ADDRESS: 247 Old Line Ave Laurel, Maryland 20707				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Blunt injuries to head and chest with complications

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐	
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 7:36PM 1-21-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject beaten	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): house	21f. LOCATION STREET: 10903 Briarwood Drive, GITY OR TOWN: Laurel, COUNTY: Prince Georges County, STATE: Maryland	

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide XX Undetermined manner ☐.

ACTUAL SIGNATURE: Margarita A. Korell TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-8-89

VC EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb 10, 1989	23c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery	23d. LOCATION CITY OR TOWN: Beltsville PG COUNTY: Maryland STATE		
24. FUNERAL DIRECTOR NAME / ADDRESS: Donaldson Funeral Home P.A. Laurel, Maryland	25a. DATE REC'D. BY REGISTRAR: FEB 15 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall			

(10)

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

021934 FEB 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05801

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remind [illegible] with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ELLEN	MIDDLE	LAST: GAVRISHEFF	2a. DATE OF DEATH MONTH DAY YEAR: 02/05/89	2b. HOUR: 5.30A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 1 1956	6. AGE (IN YEARS LAST BIRTHDAY): 32 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): GLADYS N. SPELLMAN NURS. CARE. CTR	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Commerical Artist	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Wheaton	YES ☒ NO ☐	11706 College View Dr. 20902

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Michael Gavrisheff	Darinka Gavrilocic

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
N/A	N/A	577-70-1767	Michael Gavrisheff-father-(same as 13e)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	HYPERPYREXIA	DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	CENTRAL FEVER	MONTHS
DUE TO, OR AS A CONSEQUENCE OF (c)	POST MENINGITIS CEREBRAL INJURY	MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: SYSTEMIC LUPUS ERYTHEMATOSIS.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/5/88 to 2/5/89 that (I) (we) last saw [illegible] alive on 2/3 19 89 and that (to my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature] for MB Yaffee M.D.	MD		2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
[signature] for MB Yaffee M.D.	7500 Greenway Ctr Dr Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-7-1989	Rock Creek Cemetery	Washington, DC

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home 11800 N.H. Ave., Sil. Spr. Md.	FEB 6 1989	[signature]

024597 MAR -3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05802
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial or removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes," any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
HAROLD	A.	GIBSON	2 - 20 - 89	10:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
M	B	4 13 23	65 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH		
PENNSYLVANIA	U.S.A.		P.G. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON	CLINTON CONV. CENTER	SECURITY GUARD	Security		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
D.C.	N/A	WASHINGTON, D.C.	YES ☒ NO ☐	1621 DOUGLAS ST. NE 9999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Edward	L.	Gibson	Lizzie		Bruce

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
WW II	216-18-0699	Edith Williams-Same as # 13 above	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma from prostate — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (b) prostate Carcinoma — 5 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Cachexia decubitus ulcer, Anemia 2° to D

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
N/A	N/A	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
		N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/11 19 88 to 2/20 19 89, that (I) (we) last saw the deceased alive on 2/20 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bernadette Soddo MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Bernadette Soddo MD — 22e. ADDRESS: 1106 Spring St. Silver Spring Md 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BP	2/24/89	LINCOLN MEM. CEM.	SUITLAND, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS: H.S. WASHINGTON & SONS 4925 BURROUGHS AVE. N.E.

25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989 — REGISTRAR'S SIGNATURE: Tisha Davidson-Randall

DHMH - 16 50M 4/82 (VRA 15, 4)

Security

D.C. N/A x

Edward L. Gibson Lizzie Bruce

WW II Edith Williams-Same as # 13 above

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 005803
REG. NO.

22594 FEB 13

1. DECEASED NAME (TYPE OR PRINT): First Marjorie (MARGE) Middle H. Last Gilbert (GILBERT)

2a. DATE OF DEATH: Month Feb. Day 3, Year 1989

2b. HOUR: 3:45 pm

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: Month Sept. Day 4, Year 1921

6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Vermont

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 8600 Canberra Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Paralegal Specialist

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Pr.George's

13c. CITY OR TOWN: Clinton

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 8600 Canberra Dr. 20735

14. FATHER'S NAME: First Ray Middle Last Hadley

15. MOTHER'S MAIDEN NAME: First Bessie Middle H. Last snide

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): n/a

16b. SOCIAL SECURITY NO.: 022-12-4531

17. INFORMANT: Ada May Smith ADDRESS: same as 13 a-e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA OF The LUNG — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: BRAIN METASTASIS

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/30 19 84 to Feb 3 19 89, that (I) (—) lost saw the deceased alive on 10/29 19 88, and that in (my) (—) opinion death occurred on the date and hour and from the causes stated above. (I) (—) did (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frank M. Ryan M.D.

22e. ADDRESS: 9401 Indian Head Hwy, Ft. Wash Md 20744

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Feb. 4, 1989

23c. NAME OF CEMETERY OR CREMATORY: Lee Crematory

23d. LOCATION: CITY OR TOWN Clinton, COUNTY P.G. STATE MD

24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc. ADDRESS: Old Alexander Ferry Rd., Clinton, MD 20735

25a. DATE REC'D. BY REGISTRAR: FEB 09 1989

25b. REGISTRAR'S SIGNATURE: Julia Pinkson-Lindsey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

P

BP

DHMH - 16 50M 4/83
(VRA 15, 4) 6633

024338 MAR -2 91 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05304
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Bertha GILLESPIE			2a. DATE OF DEATH MONTH DAY YEAR	February 23, 1989
				2b. HOUR	8:30P M
3. SEX	Female	4. RACE	Black	5. DATE OF BIRTH MONTH DAY YEAR	Feb. 11, 1905
6. AGE (IN YEARS LAST BIRTHDAY)	84 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	North Carolina	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Prince Georges MD.				
10. CITY OR TOWN OF DEATH	Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Doctors Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Univ.N.C.
12b. KIND OF BUSINESS OR INDUSTRY	Laundry				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	P.G.	13c. CITY OR TOWN	Bowie
13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET ADDRESS	16102 Pointer Ridge Drive		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Benjamin F. Morrow	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Mary E. Cotton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	240-58-0550
17. INFORMANT ADDRESS	Flora Fisher 16102 Pointer Ridge Dr.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary arrest	Minute
DUE TO, OR AS A CONSEQUENCE OF (b)	Sepsis	Days
DUE TO, OR AS A CONSEQUENCE OF (c)	Infected decubitus ulcer	Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe dehydration, Bilat- CVAs, HTN

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-20 19 89, to 2-23 19 89, that (I) (we) last saw the deceased alive on 2-23- 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Pritam S. Saini	DEGREE	MD
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED	2-24-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	PRITAM S. SAINI	22e. ADDRESS	14333 LAUREL-BOWIE RD #303, LAUREL, MD 20708

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	Feb. 26, 89	23c. NAME OF CEMETERY OR CREMATORY: Chapel Hill Mem
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Chapel Hill / N.C.			
24. FUNERAL DIRECTOR NAME	Hunt Funeral Home	ADDRESS	2801 7th ST. N.E. D.C.	
25a. DATE REC'D. BY REGISTRAR	MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE	Gina Davidson-Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024997 MA1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005805 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Leonard	MIDDLE:	LAST: Gilliam	2a. DATE KNOWN OF DEATH ESTIMATED ☐	MONTH: Feb. DAY: 10 YEAR: 19 89
2b. HOUR OF DEATH	2:55 P.M.				
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Blk	Dec. 15 19 00	88 YRS.		
2c. DATE PRONOUNCED DEAD	MONTH: Feb. DAY: 10 YEAR: 19 89	2d. HOUR	2:58 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Virginia	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.
10. CITY OR TOWN OF DEATH	Lanham	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Am. Doctors Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired
12b. KIND OF BUSINESS OR INDUSTRY	Government				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md	13b. COUNTY	Prince Georges	13c. CITY OR TOWN	Mitchellville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS	11503 Burning Tree Rd 20716			
14. FATHER'S NAME FIRST	Robert	MIDDLE	LAST	Gilliam	
15. MOTHER'S MAIDEN NAME FIRST	Julia	MIDDLE	LAST	Wesley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	N/A	16b. SOCIAL SECURITY NO.	487-12-7911
17. INFORMANT	Diane Carroll	ADDRESS	11503 Burning Tree Ct Mitchellville, MD.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Dis.	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Dept MEDICAL EXAMINER DATE SIGNED: Feb. 10 1989

EXAMINER'S NAME (TYPE OR PRINT): _____ ADDRESS: _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	February 16, 1989	Maryland National	Laurel, Maryland	
24. FUNERAL DIRECTOR	John T. Stewart, III	ADDRESS 4001 Benning Rd., N.E.	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Stewart Funeral Home	Wash. D.C.		FEB 21 '89	[signature]

07 84 25M

BP

DHMH - 17 (VR A15 ME (5))

022997 FEB 19 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053805 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body from the state. If the medical examiner must be notified of case, IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trouble, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	FRANCES E. GOODWIN			2a. DATE OF DEATH — MONTH DAY YEAR	2. 7. 89
2b. HOUR	8.40 AM				
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH — MONTH DAY YEAR	March 6 1895
6. AGE (IN YEARS LAST BIRTHDAY)	93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Illinois	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	PRINCE Georges Co MD.				
10. CITY OR TOWN OF DEATH	CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	So. MARYLAND HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	N/A				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Pr. Georges	13c. CITY OR TOWN	Suitland
13d. INSIDE CITY LIMITS?	YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE	2713 Lewis Ave. 20746		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	James M. Lewis	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	N/A		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	577-68-3943
17. INFORMANT — ADDRESS	Connie F. Williams	2109 Patrick St. Woodbridge, Va. 22191			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) [illegible] — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Pul. Edema 1hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Senility, Dehydration

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 02-01-89 to 2-9 19 89, that (I) (we) last saw the deceased alive on 2-9 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	[signature]	DEGREE MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2.7.89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Abulhasan U. Ansari M.D.	22e. ADDRESS	8926 Woodyard Rd. #101 Clinton, Md. 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	2-9-89	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Brentwood P.G. Md.			
24. FUNERAL DIRECTOR — NAME / ADDRESS	G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.	25a. DATE REC'D. BY REGISTRAR	FEB 9 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP ___

DHMH - 16 50M 4/83
(VRA 15, 4)